# HEALTH CARE THE 80s AND BEYOND

## SEEKING CONSENSUS

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## Preface

Publication of this report marks the culmination of the first phase of a consultative health planning process initiated by my predecessor, the Honourable Larry Grossman.

Through a series of conferences, health care providers, consumers and government representatives met together to discuss the future of health care in Ontario. One of the most difficult tasks faced by the many hundreds of people who participated in the process was balancing the sometimes conflicting desires and expectations of various parts of the health care system. The agreement reached on health issues and reported in the following pages is a tribute to the ability and commitment of those who accepted the challenge to become involved in improving health care in Ontario. I would like to emphasize that this report is not a Ministry statement of policy. The ideas, suggestions, recommendations and advice contained in this report represent the combined opinion, expertise and efforts of participants. They are a response to our request for advice on how best to manage Ontario's health care system. Although the Ministry of Health and its advisory bodies, the Ontario Council of Health and the District Health Councils, were involved in organizing conferences and collecting the ideas developed at each stage of the consultative process, recommendations and suggestions are the accomplishments of conference working groups.

I am most pleased with the overall success of this consultative process. It was reassuring to hear that there is general agreement that we do have a high quality health care system. I recognize that we must strive to maintain this high quality. I would like to take this opportunity to thank and congratulate everyone who participated in the consultative conference process and to affirm my commitment to this approach to health care planning. I will consider carefully the advice in this report, and I look forward to the next phase. If we proceed with the same level of commitment, initiative and excitement, we will succeed in our objective of evolutionary reform of Ontario's health care system. We will create a system ready to meet the needs of Ontarians through the 1980s and beyond.

The Honourable Keith C. Norton
Minister of Health
December 1983.

## Introduction

Shortly after his appointment as Ontario Minister of Health in February, 1982, the Honourable Larry Grossman identified a number of factors that pointed to the need to develop a long-term, strategic health care plan for the province.

First, there was recognition that Ontario's health care system was developing on an ad hoc basis, in response to crises, rather than as a result of a carefully-considered and well-thought-out plan. Until the 1980s, health planners had focused their energies on development of the system. Since funds to maintain the system were adequate and readily available, and the ministry was generally able to deal effectively with crises as they arose, there was no immediate reason to take an in-depth look at health care, or to develop a long-term plan for its management.

The 80s present a new scenario. In addition to financial constraints and an explosion in health care costs, demographic, political and technological changes all create stresses on the system. An aging population presents its own challenges for social and health services. Consumer expectations are high, as is their desire to participate in changes which affect them.

Taking all of this into account, the Minister decided to embark on a process that would eventually lead to a carefully reasoned long-range health care strategy for the province of Ontario. Mr. Grossman recognized that all major vested interest groups would have to be involved in the process -- on a multi-lateral basis, instead of a series of bi-lateral presentations to the Minister. Without their active participation, he felt it would be impossible to bring about required changes. "No Minister of Health -- and no Ministry of Health acting alone -- could implement all the necessary solutions in isolation."

Therefore, during spring and summer, 1983, Ontario health care providers and consumers were provided with a unique opportunity to discuss development of a long-range plan for health care in the province. Through a series of conferences, participants were asked to try to reach a consensus about the health care system Ontario should develop during the 80s and advise the Minister of Health how such a system could be achieved.

The consultative process was used to encourage consensus among a large number of committed people from a variety of backgrounds and with different viewpoints. The consultative approach to health planning recognizes the importance of involving people in the system in deciding what changes and improvements should be made.

This report documents results of the process. It reflects ideas, opinions, suggestions, concerns and recommendations from all conferences. Opinion on problems and directions for

Ontario's health system is fairly consistent. Although groups at various conferences may not have agreed on specific actions, and although perceptions of priorities varied in different parts of the province, there is general agreement on major issues the health sector must face.

As part of conference evaluation, participants were asked for opinions on the process itself. The consultative process was endorsed as a desirable and necessary approach to health planning and participants were enthusiastic about their continuing involvement in it. Many individuals commented on increased awareness of others' problems and indicated their determination to take them into future consideration.

## The Process

Recognizing the need for a new approach to managing Ontario's health system, the Minister looked for advice from those directly involved in health care. To establish a formal mechanism to request and receive that advice, the Minister embarked on a process of consultation. A major component of the consultative process was strategic planning.

### Consultative Process

It is difficult for those affected by change to see beyond their area of interest to recognize the need for equitable change for all. By involving a wide range of organizations in the process, by making it consultative, and by allowing free exchange of ideas among various groups, it was felt participants would recognize concerns and needs equally as valid as their own. This would, in turn, lead to a more balanced appraisal of future desires and directions for health care in Ontario.

This consultative approach to planning creates a co-operative environment in which change is possible. Consultation with those involved in the system means ideas for change are generated from within, not decided unilaterally which, in turn, means resulting change will be more successful and beneficial.

### Strategic Planning Process

To develop a long-term approach to health care in Ontario, a method, or framework, for planning was required. After examining alternatives, the Minister selected strategic planning as the process for consultation and long-range health planning.

The concept of strategic planning, as implemented by the Minister, has three main principles: it is an iterative process; it involves broad-based participation; and it requires commitment by participants both to the process itself and to implementation of its results.

#### The iterative principle

Strategic planning works on the basis of continuous development and refinement of ideas, or iteration. Plans or suggestions developed at one stage in the strategic planning process are consolidated and presented at the next stage for further enhancement, consolidated again and passed on to the next level or stage and so on. In this way, ideas are explored, developed, tested and improved. Resulting recommendations reflect the collective expertise of all who have contributed to the process.

### Broad-based participation

The second principle of strategic planning deals specifically with participation. To ensure effective development of planning ideas, a wide range of people from different backgrounds, with specific interests in health care, must be involved.

### Commitment

The last principle of strategic planning requires commitment by participants, not only to the process itself, but to implementation of resulting recommendations.

Although it is impossible to predict the exact course the process will take, participants have been requested by the Minister to assist in determining direction for the next phase.

### Basic steps in strategic planning

The strategic planning process, as applied by the Minister, has four basic steps:

- Assessment of where the health system is now
- Determination of where the health system should be in the 1980s and beyond
- Assessment of the gap between where the system is now and where it should be
- Development of strategies and action steps to get to where the system should be

These four steps formed the basis for workshops conducted at the Minister's Third Planning Meeting, the Minister's Policy Conference and the regional conferences.

## Phase one — The conferences

Ideas and recommendations for health care were developed through a series of meetings and conferences called by the Minister. Some detail about organization of conferences, selection of participants and workshop topics may serve to build the framework for the ideas and recommendations that emerged from the meetings.

### Minister's first planning meeting

The Minister met with a small group of advisors, including senior ministry executives, community representatives, members of the Ontario Council of Health, and guest speakers, in July,

1982, to discuss health policy issues. The group examined effects those issues may have on the future of health care, and debated the possibility and practicality of developing a province-wide strategic plan.

**Minister's second planning meeting**

Based on the results of the first meeting, the Minister called a second conference in September, 1982. The meeting brought together senior ministry personnel, members of the Ontario Council of Health, guest speakers and some health care professionals invited by the Minister. Participants came, not formally to represent any group, but to offer their own perspectives on health care in Ontario. Continuing the work of the first meeting, the group discussed obstacles which could hinder or prevent desired improvement in the system.

**Minister's third planning meeting**

At this stage in the consultative, strategic planning process, the Minister consciously broadened involvement. The meeting, sponsored by the Ontario Council of Health, was held in February, 1983, and included senior ministry personnel, members of the Ontario Council of Health, a guest speaker, a group of health experts invited by the Minister plus representatives of three major provider groups: the Ontario Medical Association (OMA), the Ontario Hospital Association (OHA) and the Registered Nurses' Association of Ontario (RNAO).

By inviting provider groups to participate, the Minister offered them the opportunity to become directly involved in planning for the health care system. It was an effort to create an environment within the system which would make change possible and to encourage a spirit of co-operation and trust between government and provider groups.

Although the concept of strategic planning had been discussed within the ministry, the Minister's third planning meeting was the first time it was formally presented to groups outside the ministry as a means of addressing system reform.

**Interest groups**

Consistent with principles of broad-based participation and extensive consultation within the health sector, the Minister met with some 80 different special interest groups between March and December, 1982. These meetings provided some insight into concerns and desires of groups not formally represented within the system. Many were consumer groups, such as the women's rights lobby and patient advocate groups.

**Some perspectives**

Recognizing perspectives within the health system vary widely, the Minister invited a number of groups to submit briefs outlining their concerns about the future of Ontario's health care system. To assist in comparing and contrasting many points of view, groups were asked to address the following topics:

- The current system -- its successes and shortcomings
- Desired directions for health and health care
- Opportunities for change
- Suggestions for action

Major sections of the briefs correspond to stages of strategic planning used at the Minister's Policy Conference, the next stage in the process.

The book of briefs, titled Health Care the 80s and Beyond: Some Perspectives, was distributed as background material to those attending the Minister's Policy Conference and/or regional conferences. It served as a forum in which groups could express their desires, and provided various groups an opportunity to consider others' views and ideas.

**Minister's Policy Conference**

The Minister's Policy Conference, convened by the Ontario Council of Health, was held in April, 1983, in Scarborough. An ambitious next step in the strategic planning, consultative process, it brought together some 240 participants, representing 60 different professional, consumer, special interest and government groups.

Invitations to attend the conference went from the Minister to various professional associations and special interest groups who were asked to nominate participants for the conference. The number of participants depended on the size and constituency of each association or group. Consistent with the principle of broadening involvement from the health sector, the Minister's Policy Conference saw participation grow from the three provider groups which attended his third planning meeting to 60 provider and consumer groups. It was intended that the conference composition reflect, as closely as possible, the scope and complexity of Ontario's health care system. However, given the early stage of development of the process, there was heavier emphasis on provider than consumer participation.

The Minister's keynote address to the conference (see Appendix A) stressed the need for balanced, integrated change within the health care system. He challenged those involved in the system to talk to one another about how to achieve a

desirable health system. Participants were asked, while representing their various organizations and affiliations, to try to set aside vested interests and to plan for an equitable, effective and efficient health care system.

The 2-1/2 day conference focused on workshop discussions. Participants were divided into 18 working groups. Every effort was made to make working groups microcosms of the conference itself. Providers, consumers and government representatives were distributed as evenly as possible among the groups.

The conference was divided into four workshop sessions. Participants met in plenary sessions before each workshop. A guest speaker introduced the workshop theme, and attempted to provide a focus for group discussions. Participants moved into working groups. Group results and recommendations were collected, organized and presented in plenary sessions following each workshop. Workshop topics were:

- The current system: its successes and shortcomings
- Trends and opportunities for change
- Desired directions for health and health care
- Preparation of action steps

In addition to the briefing book, Some Perspectives, participants were given a workshop guide, Planning for Health, prepared by the Ontario Council of Health.

To ensure working groups functioned smoothly, volunteers were trained to facilitate group discussions. At a weekend training session before the conference, facilitators were taught techniques to optimize and summarize discussion. Facilitators were responsible for communicating major points raised by their groups for presentation to plenary sessions.

Each working group also had a recorder who took down proceedings of each workshop and reflected, as accurately as possible, key points in each discussion. Their notes were the source of material used to produce two conference newsletters listing issues raised in working groups.

Their notes were used also to prepare the report on the Minister's Policy Conference contained in the next chapter.

**Regional conferences**

Over a period of eight weeks, from the end of May to the end of July, 1983, a conference was held in each of six Ministry of Health planning regions. Sponsored by district health councils (DHCs), regional conferences followed closely the design and format of the Minister's Policy Conference.

Approximately 100 participants were invited to each conference. Half were nominated by provincial groups, and half by local district health councils. They represented health professions, associations and special interest groups such as the OMA, OHA, RNAO, Ontario Nursing Home Association, Ontario Health Coalition, Patients' Rights Association, Ontario Public Health Association and many others. (For complete lists, see Appendices.) In most cases associations and organizations were asked to nominate participants familiar with health care in the region.

Regional conferences continued to broaden the process of consultation on health care, to advise the Minister of Health on future directions for the system and to assess to what extent recommendations of the Minister's Policy Conference represent regional perceptions of the health care system.

The Minister addressed each conference at its opening session, giving his view of the problems and challenges facing Ontario's health sector.

His speech was followed by a presentation on strategic planning and a brief summary of concerns and recommendations which emerged from the Minister's Policy Conference.

In addition, participants received the briefing book, Some Perspectives, a participant's guide which briefly described the consultative process, and for each of two workshops, a workshop sheet which contained a longer discussion of the suggestions and recommendations from the Minister's Policy Conference. Participants were asked to react to material from the Minister's Policy Conference, but not to feel limited to those issues.

Topics for workshop sessions were:

- Strengths and weaknesses in Ontario's health care system today
- Proposals for change: health care the 80s and beyond

Divided into six working groups (seven at the Central East Regional Conference), participants compressed the strategic planning process into two workshops held over a day and a half. Every effort was made to ensure groups reflected composition of the conference. As far as possible providers, consumers and other participants were distributed equally among working groups.

Following the format of the Minister's Policy Conference, facilitators were used to guide and summarize group discussions. Recorders noted suggestions and ideas developed. Working with a conference facilitator, facilitators and recorders synthesized group ideas and recommendations for presentation at plenary sessions.

The final plenary session consisted of presentations of group reports from the second workshop on proposals for change. A "reporter" was selected from each group to make the group's closing presentation.

At the close of each conference a preliminary report was prepared and submitted to the Minister. Reports attempted to capture regional views of Ontario's health care system.

The six preliminary reports, recorders' notes, flipchart sheets, and group reports were used to provide data for this report. Data from all six regional conferences have been amalgamated to reflect recommendations of all 37 working groups, and offer a provincial perspective on health care in Ontario, which takes regional viewpoints into account.

# Minister's Planning Meetings

## Managing Ontario's health care system

Participants at the Minister's first planning meeting, held in July, 1982, discussed four possible options for managing Ontario's health care system. They were:

- Maintain the status quo
- Make some essential adjustments
- Undertake evolutionary reform
- Make significant structural changes

Based on group discussions, the following conclusions were reached.

### Maintain the status quo

It was felt to maintain the status quo would be politically safe in the short term but would not address long-term structural problems. Because it would deal with problems individually rather than rationalizing the system, it would be expensive. Over time, maintaining the status quo would likely hamper Ontario's fiscal capacity to continue the existing system.

### Make some essential adjustments

The approach of making some essential adjustments would enable the system to maintain the status quo and address most critical issues. It would be more expensive than maintaining the system as it is now; require additional funds or reordering of priorities; and involve short-term political problems.

### Undertake evolutionary reform

A process of evolutionary reform would address long-term issues and strengthen the existing health care system. It could create some short-term political problems by unsettling interest groups and would incur higher front-end costs but result in significantly reduced future costs. It would require either new or reallocated funds.

#### Make significant structural changes

Significant structural changes to the system would require introduction of a range of new incentives based on market forces, competition and rewards for appropriate use by providers, consumers, institutions and agencies.

#### Accepted option

The first two options, to maintain the status quo and make some essential adjustments, were rejected as being impractical and expensive over the long run. It was felt the system cannot afford to continue as it has in the past, responding only to crises.

Evolutionary reform, supported by some significant structural changes to the system, was accepted as the most appropriate means of managing Ontario's health care system. The concept of evolutionary reform involves a process of gradual change, based on careful, long-range planning.

### Obstacles to change

In response to results from the first planning meeting, the Minister convened a second meeting in September, 1982. A group of ministry personnel, advisors and health experts accepted the concept of evolutionary reform with some structural changes, and examined obstacles which could hinder or prevent desired reform of the system. Five major obstacles to change were discussed:

- Lack of an overall provincial health care strategy
- Existing funding policies
- Focus on illness instead of health
- Protective behavior of provider interest groups
- Public attitudes

#### Lack of an overall provincial health care strategy

Reports from the meeting indicate lack of an overall health care strategy creates problems at the local level, among provincial ministries, and between provincial and federal governments.

Lack of an overall health strategy limits effectiveness and continuity of local health planning. Although DHCs have been able to develop plans for health care at the local level, they have had to plan within a vacuum, with little guidance from an overall provincial strategy.

At the provincial level, lack of an overall health strategy limits opportunities for co-operation and co-ordination between the Ministry of Health and other ministries. Participants talked about problems between Health and the Ministry of Community and Social Services over nursing homes and homes for the aged; care for the mentally retarded; and home care and community-based services. Manpower planning creates problems between Health and the Ministry of Colleges and Universities. Health and Housing sometimes differ on issues of housing and shelter for the aged and ex-psychiatric patients. An overall health strategy could create an environment in which various ministries could co-ordinate services.

The province is perceived as having difficulty dealing with the federal government on health issues. A clear provincial strategy would help the province communicate more effectively with Ottawa.

**Existing funding policies**

Participants noted a number of existing funding policies reinforce the status quo and limit effective reform of the system.

In general terms, they discussed disincentives for change created by the present system of funding. They noted centralized funding does not encourage innovation. Fee-for-service, although an integral part of Ontario's health care system, has its limitations: it reduces opportunities for flexibility, innovation and change. The present funding system does little to reward efficiency, reform or creative change.

Participants also pointed out that rigid government attitude towards cost-containment may, in the long run, cause more expense. They noted the province's immediate focus is to contain costs. It is reluctant to invest in the future of health care, even when investment now might reduce costs over the long term. They suggested government take a broader view. The present focus will inhibit, or prevent, constructive change.

**Focus on illness instead of health**

Concern was expressed that health promotion is a much neglected part of health care in Ontario. Legislation and funding make little provision for health promotion, making it unlikely to become a thrust of the system. The system is geared towards illness treatment. This focus emphasizes illness and limits the system's ability to shift to an attitude of health. Without greater emphasis on health promotion, other reforms and changes within the system will be difficult.

Participants also noted the system's tendency to invest in technology as a means of treating illness. Although technology is an increasingly significant component of health care, there may be more appropriate, less costly, more health-oriented ways to deal with some health problems.

**Protective behaviour of provider interest groups**

Those attending acknowledged the political power of special interest groups within the system. When provider pressure is strong enough, it is able to either direct or inhibit reform of the system. Participants noted, too, there seems to be antagonism between government and special interest groups and among various special interest groups themselves. This attitude, and resulting lack of co-operation, will severely limit change in the system.

**Public attitudes**

Another force against change is public attitudes. Although people in Ontario are generally satisfied with the level of care, there is an apparent but undefined sense of dissatisfaction. Although the public is increasingly aware of its responsibility for health, it feels powerless within the health care system. These contradictions may create a climate in which change is difficult.

At the same time, Ontarians, like other Canadians, have high expectations of government. They believe government should provide quality health care. Political pressure resulting from those expectations may limit the system's ability to change.

**Conclusion**

According to the group, if these five obstacles to change could be overcome, reform of Ontario's health care system would be possible. Considering the range of groups identified which can inhibit change -- other ministries, the existing system, providers, public -- the meeting confirmed and reiterated the need for broad-based involvement and consultation in developing a strategic plan for health care.

The conclusion that those within the system can impact on the system's ability to pursue evolutionary reform led to the next stage in the consultative process.

**Developing a climate for change**

At the third stage in the series of consultations on health care, the Minister broadened the process to include representatives of three major provider groups. The meeting, sponsored by the Ontario Council of Health, was held in February, 1983. Participants applied the strategic planning process to major issues facing the health care system such as funding, rationalization, health promotion, public and professional health education, primary care, community-based care, technology, research and development, manpower planning and roles of health professionals.

Although results of discussions were interesting and informative, the value of the Minister's third planning meeting lay in the fact that it allowed three influential provider groups to become involved in planning for Ontario's health care system and to test the strategic planning process advocated by the Minister. Participants endorsed the process, and this support became an integral part of the potential value of the approach. It was at this stage the Minister asked for and received commitment of major provider groups making it possible to move on to the next stage in the process.

## The Minister's Policy Conference

The Minister's Policy Conference was attended by some 240 representatives of 60 different professional, consumer, special interest and government groups.

The conference examined four aspects of health care in Ontario:

- The current system: its successes and shortcomings
- Trends and opportunities for change
- Desired directions for health and health care
- Preparation of action steps

The Ontario Council of Health has prepared the following analysis of workshop results. Issues discussed varied from group to group and agreement or consensus ranged from widespread or major (i.e. common to a number of the 18 working groups) to limited or minor (i.e. suggested by one or two groups). Accordingly, issues presented here indicate whether agreement was major or minor.

It should be stressed that the ideas and recommendations discussed in this chapter do not reflect official policy. Rather they are the opinions of conference participants presented here for consideration by the Minister.

## The current system: its successes and shortcomings

The first workshop asked participants to examine the current health care system by identifying its strengths and weaknesses. What is good about the system? What needs to be improved?

### Major agreement

### Strengths

#### Favourable public perception

People in Ontario have high expectations of the health care system. Some perceive that the hospital system is good, and others like the variety and mix of available health professionals.

### Trend towards deinstitutionalization

The recent trend towards community-based alternatives to institutional care was identified as a system strength. Participants saw this as a step in the right direction and noted the system seemed to be willing to change to meet needs of Ontarians.

### Universal and accessible system

In general, Ontario has a universal and accessible health care system. In particular, access to clinical services is a strength.

### Effective cost containment

Unlike other health care systems in the western world, Ontario's system has succeeded in containing costs effectively.

## Weaknesses

### Lack of co-ordination and continuity of care

According to participants at the Minister's Policy Conference, co-ordination of health services and continuity of care suffer from internal problems: poor relationships between health professionals; disputes over jurisdictions of practice; proliferation of self-defined health professions; the lack of a team approach to health care; and the absence of 24-hour service in many areas. Lack of co-ordination and continuity of care were considered major weaknesses.

### Financial, geographical and functional barriers to access

Although Ontario's health care system generally is considered to be universal and accessible, participants were concerned about certain barriers to access: financial barriers for those with low incomes; lack of manpower and services in certain parts of the province; and the lack of OHIP coverage for comprehensive services such as dental and home care. These barriers to access were considered to limit effectiveness of Ontario's health care system.

### Lack of a global/strategic plan for health care

With no global or strategic plan for health care in Ontario, the system continues to be oriented to crisis management rather than long-range planning. Lack of long-range planning limits the system's ability to respond to future health care needs.

### Lack of accountability

Group discussion focused on provider responsibility and accountability. Participants particularly noted the lack of accountability with regard to quality of care.

### Lack of financial incentives to encourage efficiencies

In the opinion of conference participants, the current health care system does not use financial incentives to encourage efficient provision or use of health care services and facilities.

### Uninformed providers

Although participants felt providers were well trained in their own areas of expertise, they thought health care providers generally were uninformed about service alternatives and options. Communication among providers is not optimal, and the system suffers from lack of a formal mechanism, such as conferences or public forums, to promote effective communication between providers and consumers.

### Misuse of technology

In discussions about appropriate levels and types of care, some concern was expressed about misuse of technology in health care. Participants noted, in some cases, high technology may not be the most appropriate type of care but, because of the current fascination with technology, it is widely and perhaps inappropriately used.

### Lack of information systems and applied research

Examining potential for innovation in the current system, participants identified a lack of information systems and applied research. Without this data base, they felt the system's ability to be innovative was limited.

### Inflexibility

According to conference participants, centralized functions of the health care system can make it inflexible to local variations.

## Minor agreement

There were several other strengths and weaknesses discussed by a small number of groups.

## Strengths

Some delegates thought the very fact the ministry was aiming for change through consensus was a strength. The existence of consumer education programs was seen as positive. In terms of universality and accessibility, affordable health care services were identifed as a strength. Others listed public financing, well-managed institutions, a strong voluntary community, and continuity of care.

## Weaknesses

As weaknesses, some delegates identified: the number of ministries involved in health issues; a lack of linkages between various groups and levels; conflicts between patients, practitioners and governments; problems in planning and management of the system; and incentives which lead to competitiveness and inefficiency.

In terms of the shift towards community-based care, some felt that community support services were lacking or, where they did exist, were primitive; that those already in existence should be evaluated; and that better use should be made of public health nurses.

In discussions about uninformed providers, it was suggested: provider education is inadequate; there is insufficient information available to providers (and consumers) on alternative or optional services; there is lack of communication among providers themselves; and both providers and the public have unrealistic expectations about what the health care system can do.

Inequitable involvement in the system was seen as a weakness: providers and government dominate health policy development; physicians have disproportionate control over areas other than medical care; and there is lack of representation from consumers, native organizations, the elderly, womens' groups and unions. Because of this lack of representation, it was felt that consumer dissatisfaction may be overlooked.

Concern was expressed about effective use of health care professionals. Some groups noted, as weaknesses, inappropriate use of personnel, overtraining of personnel, lack of a team approach, and inability of professionals to transcend vested interests.

Several participants suggested the appropriate level of care is not always used: there is too much emphasis on care being given through institutions; not enough alternatives to hospitalization are available; incentives encourage over-use of secondary and tertiary care; and there is a need to rationalize services.

In terms of system financing, some felt funding mechanisms themselves lead to inefficiencies. They suggested public funding leads to politicization and mixed priorities; general funding emphasizes institutional care; funding mechanisms fail to follow planning; and there is a lack of financial incentives to encourage efficiencies. Others felt that lack of cost awareness by both consumers and providers is a weakness. Lack of consumer compliance with treatment represents another inefficiency.

In terms of health promotion and disease prevention, some delegates felt the system has failed to address the social causes of disease: there is lack of recognition of the part economic and corporate activities play in creating ill-health; it is difficult to research health and health promotion; and there is no broad definition of health.

## Trends and opportunities for change

Working groups looked at outside pressures for change and asked themselves: will the health care system be suited to various broad societal changes which are occurring?

### The broader environment: trends for change

The objective of the first part of the second workshop at the Minister's Policy Conference was to consider conditions outside the health sector likely to affect its existing or future direction.

### Major agreement

There was agreement the health care system will be faced with pressures from:

- Economic factors
- Changes in the nature of work
- Demographic changes
- Organizational changes

#### Economic factors

Limited funds, the present climate of restraint or constraint and reduced federal transfer funds were identified as pressures which would impact directly on Ontario's health care system. Underfunding of health research and development, in response to the limited funds available, will make the system less able to respond to future health needs.

Current and projected levels of unemployment have economic implications for health care, as does increasing privatization of health services. Both threaten users' ability to pay for care required.

**Changes in the nature of work**

Increasing employment in service occupations, increasing professionalism, rapid changes in jobs and the work force were all given as current employment trends which could impact on the health care system. Increased use of technology, less labor-intensive work and more leisure time are likely to influence demand for health services. Participants also noted the increasing role of women in society and the tendency toward early retirement as factors likely to affect health care. Increases in stress-related illness, due to changes in nature of work, are creating pressures on the health care system.

**Demographic changes**

Demographic changes will put new pressure on the type and organization of health services in Ontario. Participants discussed the changing family unit, increase in single parents, decrease in fertility and larger dependent population. Life expectancy is increasing, and a growing proportion of the population is made up of older people. Other demographic factors may also impact on health care: greater social mobility, more heterogeneous cultural groups, more urbanization and a more highly educated, demanding public.

**Organizational changes**

According to participants, changes in the larger social environment are likely to affect health care. They noted a steady increase in government involvement and regulation; the move from centralized to decentralized decision-making; and the move away from organized religion. These changes in attitudes and practices may impact on the way in which health services are organized and administered.

Within the system itself there are pressures for organizational change. The system is already developing alternatives to conventional delivery systems and those alternatives require different types of organization. Pressure to move from institutional to community-based care is strong and growing. Efforts are underway to rationalize delivery of health care services. There is pressure to increase the scope of practice for a variety of practitioners.

### Minor agreement

A smaller number of working groups agreed there are other pressures on the health care system:

- Changes in pattern of morbidity
- The information revolution
- Shifts in public perception
- Increase in consumer participation
- Shifts in public expectations

#### Changes in pattern of morbidity

The pattern of disease and illness is changing and, to be effective, the health care system will have to respond. There is more stress-related illness and greater recognition of occupational and environment-related disease. There is less need for acute care, but greater demand for chronic care. The present system will have to shift to meet changing health needs.

#### The information revolution

Information is more available than ever before. Those working in health care want to have access to all available knowledge. While increased use of computers makes information more accessible, it increases the volume of data with which the health system must deal. With a more information oriented public, media play more active roles and media comment and criticism become pressures for change.

#### Shifts in public perception, increase in consumer participation and shifts in public expectations

These pressures for change all relate to basic shifts in public attitude. There is public pressure for more support services and more appropriate health-related services. People are less likely to accept without question what the health system offers. There is some indication people are taking more responsibility for their own health. They recognize the influence of lifestyle on health status. Public concern about health care is evident in the number of self-help groups, patient rights lobbies, high levels of volunteerism, and in family involvement. Concern about accountability and litigation and about health ethics is widespread and increasing. With people less willing to be passive in the health care system, there will be strong pressures for change.

## Opportunities for change

Part of the second workshop involved examining trends and pressures in the broader environment and identifying positive opportunities for change within the system. Participants also considered strengths and weaknesses discussed in the first workshop, and suggested opportunities for change:

- Social trends
- Financial and economic trends
- Organizational trends
- Technological trends

### Social trends

According to participants, there are a number of social trends which could lead to positive changes in health care.

Positive attitudes towards collaborative and collective behavior, with the increased availability of information, could improve system co-ordination.

Increases in community programs, public lobbying and consumer involvement could help develop a community-oriented health care system. Increased financial stability for the elderly due to pension reforms may lead to a more accessible system.

Capitalizing on public involvement, self-help education could create an opportunity to inform providers and consumers about health and the system.

### Financial and economic trends

Financial constraints and greater privatization may create opportunities to increase effectiveness and efficiency.

Recent attention to fee-for-service, rationalization, and other financial aspects of health care may help to develop an environment in which the system can explore alternatives, incentives and cost-effective substitution of providers and services.

New recreation and housing needs, job-sharing and other changes in the work place may provide opportunities to increase programs in health promotion and disease prevention.

### Organizational trends

Changes in organizational structures may lead to more health care flexibility and encourage broader involvement. Shifts in

other structures and institutions may encourage integration of services, provide multi-disciplinary care and rationalize services effectively.

#### Technological trends

Computer technology increases availability of and access to information. This can create opportunities for innovation via more research opportunities and it can make planned change possible.

## Desired directions for health and health care

An important step in the strategic planning process is determining where the system ought to be. To create an effective long range plan, there must be a goal. As was clear from results of the second workshop, pressures to change the system are mounting. Which directions should we take? What kind of health care system do we want? Deciding where the system should be helps establish priorities for dealing with problems and options for change.

In the third workshop at the Minister's Policy Conference, participants were asked to think 15 to 20 years into the future and imagine what a desirable health care system would look like. How would decisions be made? What would the environment be like? What sources of energy will we be using -- and what effect will that have on health care? What will be happening socially? Culturally? Economically?

A synthesis of statements ascribed the following characteristics to a desirable health care system.

#### Major agreement

The system would focus on disease prevention, health promotion and on individual responsibility for health.

Multi-disciplinary teams would ensure continuity of care.

The environment would be healthy.

To increase effectiveness and efficiency of the system, health care units would be decentralized.

People would be able to receive care in their communities or in their homes.

All services, health-related professions, research and hospital services would be co-ordinated.

There would be equity in access to comprehensive services.

Planning and organization of delivery systems would be more varied, and therefore flexible and responsive.

**Minor agreement**

Communications within the system would be better co-ordinated, as would services for seniors.

Planning, information systems, funding mechanisms and the process for consultation, advice and decision-making would be integrated.

Community support services, community health centres, hospice programs, local help for stress-related problems and community-based training for health professionals would be developed.

Patients would be more involved in treatment decisions, in advocacy, in public debate on ethical issues and in the health planning process.

To increase system efficiency and effectiveness, there should be changes in funding practices. A number of alternative suggestions were made. Providers could be paid on a per capita basis or government could fund health care as a public utility. Incentives could be used to encourage efficient use of resources. Funding authority would be decentralized. The private sector might be encouraged to be more involved in health care.

Changes in organization could also make the system more efficient. Planning would be decentralized. De-institutionalization would be encouraged. Mechanisms for setting priorities would be established. Effective services would be provided by the most appropriately skilled practitioner. Institutions could become increasingly specialized.

To encourage innovation and flexibility, research could be more widely focused and there could be greater variety in types of care offered and in payment mechanisms.

Recognizing the importance of continuity of care, working groups suggested an ideal system would be sensitive in meeting needs of the whole person, would support new professions and would work to integrate services. There would be variety in types of "gatekeepers" clients could use to gain access to the system. An improved clinical information system would help assess health status and quality of care. Care would be person-oriented, and policies would centre on services to clients. Less invasive therapies would be used, and death with dignity would be a consideration in patient treatment decisions.

In an ideal system, most people would try to lead a healthy lifestyle. Health would be demystified; people would be more knowledgeable.

## Preparation of action steps

Against the background of desirable characteristics for the ideal health care system, and using strengths and weaknesses and pressures/opportunities for change identified in the previous workshops, participants undertook the final steps in the strategic planning process. The fourth workshop was the longest session of the Minister's Policy Conference. It asked participants to assess the gap between where the health care system is now and where it ought to be; and to develop strategies to move it in the desired direction.

### Major agreement

Strategies and specific action steps which found support in at least six groups were proposed in the following eight areas:

- Decentralization
- Data and information
- Funding and incentives
- Co-ordination
- Professional education
- Public education
- Alternative delivery systems and roles for professionals
- Public and provider involvement in the planning process

#### Decentralization

Participants discussed decentralization of authority and decentralization of health care services.

Decentralization of authority was discussed as a means of making the health care system more responsive to local needs and priorities in the belief that would lead to greater accessibility, better co-ordination and more efficient use of services.

It was discussed in many variations: complete fiscal and executive decentralization; decentralizing only planning and decision-making; a greater role for district health councils (DHCs); and creation of regional authorities either based on those already used by the ministry or formed in consideration

of criteria such as transportation, referral patterns, and natural boundaries.

It was suggested feasibility and effectiveness of activities under decentralization be studied through pilot projects.

Decentralization or community orientation of health services should be supported by the funding of home care and volunteer programs; reallocation of funds from institutions to local groups; consultation at the local level; expansion of community health centres; and consolidation of health responsibilities, currently under the jurisdiction of several community agencies, under a single local agency.

**Data and information**

To improve knowledge about health, disease, systems and mechanisms for promoting health, as well as prevention, care and treatment of disease, participants suggested development of a province-wide data base.

The data base should be integrated with Health Sciences Centre information and research and should follow national standards for data collection that could be developed by the federal government.

The purpose of such a data base would be to support basic, applied and clinical research and to monitor health programs and policies. It should support research in epidemiology, roots of ill-health and health promotion, and evaluation of new technologies and primary prevention of disease.

In terms of supporting operational systems and health services, the data base could be used for research into: alternative models for local decision-making; integrated funding between ministries; consumer information on and responsibility for health care costs; types of services needed to meet community and special needs; accessibility; effectiveness of major health interventions and programs; and effectiveness of education and delivery of care by physicians and other health providers.

Some groups discussed the value of a good data base for monitoring and evaluating: the current change process itself; public policy and its impact on health; DHC programs; programs and policies aimed at achieving equity in access to services; needs; services in place; and gaps in service.

There was general agreement that any data base should be universal, standardized, readily available, accessible and designed to respond to the planning needs of all districts and communities in Ontario.

**Funding and incentives**

Funding and incentive alternatives were discussed as a means of supporting innovative programs and encouraging efficiencies in the system. The purpose of proposed actions is to distribute, or redistribute, limited financial resources to reflect the goals of the health care system and to provide equitable health service funding.

Specific recommendations were many and varied. It was suggested that financial incentives should reward collaborative activity; encourage efficient use of the system by government, users and providers; ensure the least costly use of appropriate personnel; attract personnel to underserviced areas; and encourage community-based services.

Some groups suggested the Ministry of Health could support innovative programs and new initiatives through an annual reallocation of one percent of total health care expenditures by 1985; a one per cent tax on patentable products of health care research and development; incentive grants to DHCs; matching and redirecting of health service resources freed due to improvements in efficiency; and decentralization of decision-making.

In terms of supporting community health, it was suggested that voluntary and community groups could be funded through a discretionary fund; remuneration incentives be given to providers working in community health field; tax credits or subsidies be provided for those providing home care; and funds be redirected from institutions into community-based services.

As a means of removing financial barriers for consumers, it was suggested that health care be totally funded from tax revenues (i.e. there would be no more premiums) and that negotiation of professional fees be binding (i.e. physicians would be either in OHIP or out of it -- there would be no extra billing).

It was also suggested that funding policies should maintain existing physical plants and equipment; support vertical and horizontal grouping of resources and personnel; support franchising by larger facilities; and protect provincial health funds for isolated areas.

**Co-ordination**

To encourage inter-ministerial co-ordination of health policies and implementation of health policy goals, groups discussed two possible approaches: either the Ministry of Health would act as the health advocate with other ministries involved in health care, or all health responsibilities would be transferred to a single ministry.

The first approach received more support. It was suggested that the Ministry of Health's lead role in health care would require certain actions. It would necessitate identification of policies in other ministries affecting health care; definition of Ministry of Health boundaries; a mechanism through which inter-ministerial co-ordination of policies, funding and health care delivery could be achieved; regulatory action to ensure continuity of care; better co-ordination of health care regulations; and establishment of cost-sharing mechanisms between ministries for hiring of health care personnel in non-medical facilities such as schools and industrial plants. Through consultation with other ministries, the Ministry of Health should be the policy setter in legislation relating to health matters.

**Professional education**

In order to match professional training with requirements and goals of the health care system, several possible changes in professional education were suggested.

Ideas included development of new careers in such areas as occupational health and health promotion; emphasis on health promotion in training; increased practical training for resident physicians; increased specialization in areas where there are manpower shortages such as gerontology and psychiatry; and emphasis on a multi-disciplinary team approach.

Re-examination of the role of teaching institutions in curriculum reform was also suggested.

**Public education**

To gain consumer co-operation and support for changes and improvements to the health care system, and to change public attitudes towards the system, a number of groups recommended public education.

Information on health promotion, disease prevention, the variety of health services available, and consumer responsibility for health care costs should be disseminated. It also was suggested that public education be facilitated through employment of adequate numbers of public health nurses.

**Alternative delivery systems and professional roles**

Alternative delivery systems and redefinition of professional roles were discussed as means of meeting the optimum system requirements (i.e. accessibility, cost-effectiveness, flexibility and so on), and to ensure more appropriate use of those already working in the system.

Professional roles should be redefined so that multi-disciplinary teams are used in primary care delivery, the most appropriate skilled practitioner provides health care services, non-medical personnel deliver some health care, someone other than a physician can act as "team captain", and self-help groups, patients and volunteers are used effectively. It was also suggested that the Ontario Council of Health study redefinition of professional roles in consultation with professional colleges.

To develop alternative delivery systems, it was suggested community health centres be encouraged, and support be given to those housing alternatives that are most appropriate to a patient's needs (i.e. home care, group homes, day care, nursing homes).

**Public and provider involvement in the planning process**

It was felt that effective, co-ordinated and innovative health planning requires participation of those with responsibility for implementing plans as well as those who will be affected by them. For this reason, a formal planning and consultation process, which involves both consumers and providers, should be continued both at the provincial and at the community or regional level.

Participants also recommended providers and consumers be educated about policy development and consulted about their required services and priority concerns.

## Regional Conferences

The eight issues outlined in the last chapter were considered of major importance by the 240 participants at the Minister's Policy Conference. As such, they were presented to participants at the regional conferences in an effort to determine the extent to which they accurately represent perceptions that people across the province have about Ontario's health care system.

As with the data from the Minister's Policy Conference, ideas, suggestions and recommendations included in this section represent opinions of conference participants. At this stage they are not policy, but advice to the Minister. Recommendations from all conferences have been put together to create a provincial perspective on health care. For a more detailed explanation on collation of data, see Appendix C, Methodology: Synthesis of Regional Conference Data.

Although there were two workshops at regional conferences, one on strengths and weaknesses and one on proposals for change, data from the workshops have been combined for presentation in the report. Discussions should make explicit strengths upon which proposals for change are building and weaknesses they are trying to address.

### Building an individual-oriented health care system

Conference participants agreed Ontario's hospital-based, acute care services are among the best in the world. As one group put it, "What we do, we do well."

In addition, Ontario boasts effective, competent health professionals who are well trained and highly qualified within their various disciplines, especially in clinical care and disease treatment.

However, disease treatment and institutionalization may not be the most appropriate way to meet changing health care needs in Ontario. While it was suggested hospital-based, acute care capabilities be maintained, development of alternatives to provide improved care through the 80s and beyond was advocated.

Crucial to the focus of the system is the individual's health needs. Health care in Ontario should not be a standard system, providing similar services to everyone, but a flexible one which responds to individual needs within local and community situations.

This attitude reflects a concern about "dehumanizing of health care." According to one group, "With the increased emphasis on technology and lack of time providers are able to spend with patients, there has been a loss of the human element of

care which has led to sadness and anxiety in patients, especially in the elderly."

A number of groups tried to capture this health care philosophy in an inclusive goal or mission statement which would direct priorities, programs and initiatives. Some suggestions were:

> "To work well together, building a healthy environment, that is rewarding to individuals who choose healthy lifestyles and that is supportive of those needing help."

> "We subscribe to the goals of health promotion and disease prevention and development of an environment (health, social and educational) in which the individual, from birth to death, may maintain optimal physical, emotional and spiritual health."

Many suggestions and recommendations were made about how to create this responsive, individual-oriented system centering on the following concepts:

- Health promotion
- Co-ordination
- Decentralization
- Community-based programs and alternative delivery systems
- Accessibility
- Funding and incentives
- Data, research and evaluation

## Health promotion

Recognizing many health problems are lifestyle or environment related, it was recommended that Ontario's health system shift its focus from illness treatment to health promotion, or, as some phrased it, "from cure to care." Rather than wait for illness or disease to develop, the health system should encourage people to adopt healthy lifestyles, and thereby prevent illness.

In some groups' view, a system which stresses health promotion would embody a holistic view of health and recognize that social milieu, education, environment, economics and health are inter-related. Those working in health care have a responsibility to look beyond illness to its possible social and environmental causes and to advocate a healthier environment.

Because many diseases are now lifestyle or behavior related, people should be encouraged to take more responsibility for their own health. The current approach to health seems to encourage people to rely too heavily on the system. A system-wide emphasis on health promotion would improve health status and encourage self-reliance and self-responsibility which would, in turn, reduce demand for health care services.

### Advocacy and leadership

The Ministry of Health should make a serious commitment to health promotion, taking a strong leadership role, developing strategies and goals for health promotion, acting as an advocate when social and environmental issues affect health, and co-ordinating involvement of all provincial ministries, agencies and local groups in health promotion programs.

A national/provincial health promotion resource could be developed to organize information and develop interventions.

An organizational structure, or designated office, such as the Secretariat for Social Development, an assistant deputy minister, a "human needs centre," or a "health promotion resource centre," could ensure that health promotion initiatives have focus and influence. At local levels, a position for a "health educator" could be created, possibly within public health units. The health educator would co-ordinate health promotion programs, refer people to appropriate care, and work with schools and other agencies and institutions. DHCs could take more responsibility for health promotion, by encouraging consumer and provider education and volunteer programs and activities.

**Public education**

Education was overwhelmingly endorsed as the most effective means to promote health and to address lack of knowledge about health promotion. Participants recommended health education for both providers and consumers, stressing the system should "teach rather than tell." Programs should be developed in co-operation with the Ministry of Education and local school boards for use at all school levels. Health and physical education should be made compulsory subjects. Stress was placed on starting programs at the primary level in an effort to influence children at a young age when it may be possible to establish healthy behavior patterns for life.

For health promotion to be most effective, participants suggested it be targeted at high-risk groups such as those with low incomes, the elderly, the obese, those suffering from stress, those with a genetic history of disease, alcoholics, battered wives, and abused children. It was suggested, for example, that health promotion programs aimed at the elderly could encourage proper nutrition and exercise to help people maintain their health.

Health promotion should take advantage of "the teachable moment" or those times at which people such as pregnant women, those recovering from illnesses, and people suffering from other lifestyle-related problems are receptive to a "health" message.

It was also suggested the public be trained in first aid and cardio-pulmonary resuscitation and the emergency number 911 be adopted across the province.

Consumer education should go beyond health promotion to encourage responsible cost-efficient use of the system. Cost of health care and quality and value of alternatives to institutionalized care should also be stressed. An aggressive health education program should deal with lifestyle and self-reliance and tackle the issue of realistic expectations of the health care system. It is important the public be aware of system limitations.

**Provider education**

Provider education is a crucial component of effective health promotion efforts. Health professionals should be educated in health promotion techniques as well as how to teach. As one group put it, "Train the trainers." Since health providers have most frequent and consistent contact with consumers they must be able to reinforce the health promotion message. Given recent health trends, participants recommended professional education should include instruction on alcohol-induced illnesses, gerontology, palliative care and other special needs to ensure providers are equipped to care for patients through the 80s and beyond.

To achieve the ultimate goal of a system which is responsive to individual needs, providers should be educated in "care" as well as "cure." Medical schools should expand their teaching personnel to stress a "pastoral approach" to health care. Professional associations should also take some responsibility for educating their members in health promotion.

To reflect a more holistic view of health, providers should be made aware of the contribution allied professions can make in encouraging healthy lifestyles, and of the potential for improving health through a team approach to care. To encourage a healthy environment, providers should advocate elimination of social and physical health hazards.

**Health promotion programs**

In terms of specific programs, a number of groups felt the ministry should use media and marketing techniques to promote health, to warn of health hazards associated with use of alcohol, drugs and tobacco and to counter negative lifestyle advertising. One group felt, however, government should not advertise because it would politicize the issue and the health promotion message would be lost.

The ministry should continue to produce and distribute health promotion pamphlets but should perhaps explore other distribution methods such as displays in shopping malls and utility bill inserts.

Film and television programs could be made available to hospitals and for public use, and health "blurbs" could be produced for use on public address systems.

Some participants, noting public information is often conflicting and confusing, asked that promotion messages be clear and consistent.

Special attention should be given to providing Ontario health care information to ethnic and immigrant groups.

Role models and celebrities could be used to promote health. Anti-smoking posters featuring Wayne Gretzky, for example, could be used to communicate effectively with children and adolescents.

There was strong support for expansion of the role of public health nurses in implementing health promotion programs and in public education. Because public health nurses have access to consumers in their homes, they may be uniquely suited to connect health with lifestyle and behavior.

Public attitudes which link hospitalization with illness limit the system's ability to promote health. To create a more health-oriented view of certain physical conditions, early discharge from hospital should be considered for women who

have given birth and for psychiatric patients, if there are adequate support services within the community.

To encourage self-responsibility for health, participants suggested the system develop self-assessment programs which would be completed and then reviewed by health professionals.

A number of community resources were identified which could be used to support or initiate health promotion programs. Groups such as the Lung Association, Canadian Cancer Society and Ontario Heart Foundation are already involved in health maintenance and should be encouraged. Service clubs could be approached to mount health promotion programs. Private sector programs such as employee recreation and fitness could be developed. Recognizing smaller companies may not have resources for employee health programs, participants suggested local health and social service agencies work with firms to develop less costly programs and incentives.

The ministry should support and encourage volunteer health promotion activities as well as self-help, mutual support and self-assessment programs. The "well" elderly, for example, could be mobilized to promote health among their peers.

As an incentive to the health system itself and to promote the shift from treatment to prevention, the ministry could ensure that any new or expanded health program have a health promotion component.

Existing health promotion programs which have been tested, evaluated and determined to be successful should be expanded.

There was concern about lack of data to support health promotion programs and it was recommended new programs be piloted and tested.

Reports from the northern part of the province suggested health promotion programs would be a logical extension of community spirit and self-reliance characteristic of the region. The ministry should take advantage of the north's receptive environment and test promotion programs there.

**Legislation**

While education was a major thrust in most health promotion recommendations, some participants questioned effectiveness of changing or influencing behavior through education and recommended strong legislation against alcohol advertising, drinking and driving, and smoking. One group suggested authorities confiscate automobiles driven by those who have been drinking; others suggested existing legislation, such as non-smoking by-laws and seat belt laws, be more strictly enforced. In addition, any proven health measure, such as fluoridation, should be supported by legislation.

A consistent screening process should be established for products which are potentially dangerous, with legislation when and where appropriate.

**Health promotion costs**

Some participants felt health promotion would eventually lead to less demand for health care services and therefore reduce costs. Others felt health promotion would not necessarily lead to savings, but would probably improve quality of life and is, therefore, a worthwhile investment.

Basic funding for health promotion should be committed and protected. It was many participants' opinion that, because results of promotion programs are often intangible and difficult to quantify, when funding problems occur health promotion is vulnerable. In order for health promotion to be successful, funding has to be consistent and secure.

Seed or transitional funding may be needed to establish health promotion programs. Funding mechanisms should be flexible enough to allow health promotion programs to meet local needs and to allow for creative development.

Other sources of funding were considered. The possibility of federal or lottery funding for health promotion should be explored.

One group suggested, in areas where there is an over-supply of professionals, the number could be reduced over the short-term and resulting savings channelled into health promotion.

Revenue from alcohol and tobacco tax was suggested as a source of funding for health promotion. However, a number of groups noted a contradiction in government encouraging people to drink less or to stop smoking while profiting from alcohol and tobacco sales.

If savings to the system are generated through health promotion, those funds should be reinvested in health promotion programs.

Expectations from promotion programs may be unrealistic. Conference participants reminded the ministry that results from health promotion would likely take a number of years and that should be taken into consideration when setting goals and evaluating programs.

**Incentives to encourage health**

Incentives were identified as a means of supporting health promotion efforts. Both consumers and providers might be more willing to change lifestyle and practice patterns if there were rewards or encouragement involved. Suggestions included

tax rebates for those who are healthy, lower insurance rates for non-smokers, and lower OHIP premiums for those who do not drink, smoke or make excessive use of the health care system.

As an incentive to providers, changes to the OHIP Schedule of Benefits were recommended. Payment for health counselling or health education would encourage providers to become actively involved in health promotion. Doctors, public health nurses and other health care professionals (nurses, nurse practitioners, health educators and so on) should be paid to provide health information, particularly to high risk groups. It was also suggested, if doctors could charge for services of other professionals, they might include such people as nutritionists or physiotherapists in their practices and thus provide a full range of health services to patients.

To encourage hospitals to undertake health promotion programs, some groups suggested the ministry match funds hospitals allocate to health promotion.

Deterrent fees (as opposed to incentives) were discussed as a means of punishing unhealthy behavior, but none of the groups could agree on their efficacy.

While using incentives to promote health, the system must also ensure there are no disincentives to health. One specific concern was the present criteria for nursing home care which seem to penalize the healthy elderly. Under current criteria, residential care costs are borne by the patient while extended care costs are paid by the system. Those who are healthy and require only residential care incur greater personal expense than those who need heavier care. These criteria should be reviewed to ensure there is no disincentive for those who stay healthy.

## Co-ordination

Conference participants in all parts of the province identified the need for better co-ordination of health-related responsibilities, programs, services and manpower. Better co-ordination would prevent service duplication, eliminate gaps, integrate health and social services and make more effective use of Ontario's limited resources. Improved co-ordination was seen as a means by which the system could become more responsive to individual needs by providing the most appropriate care.

### Governments and agencies – administrative co-ordination

Most groups discussed the problem of co-ordination and communication: between federal and provincial governments, particularly with regard to native health and funding issues; among provincial ministries including Health, Community and Social Services, Education, Labour, Environment and Treasury; between various branches and divisions of the Ministry of Health; and, at the local level, among various social and health institutions and agencies.

With regard to native health, the Ministry of Health should have prime responsibility for provision of services. It was also recommended federal and provincial ministries make use of existing health unit staff to avoid duplication of service and to improve service delivery.

As an illustration of lack of inter-ministerial co-ordination, groups discussed services available to the elderly. Nursing homes are under Ministry of Health jurisdiction while Homes for the Aged are under the Ministry of Community and Social Services. Rest homes are provided by the private sector, and the Ministry of Housing is responsible for senior citizens' apartments and other "rent-geared-to-income" housing. As an elderly person's health deteriorates, it may be necessary to move from one facility to another to receive appropriate care. To avoid disruption, participants suggested all facilities for the elderly offer some form of nursing care or have improved access to services. Co-operation among various agencies and ministries is essential to provide consistent, appropriate, quality care, particularly for the elderly.

To improve co-ordination of health and health-related services by government, some groups recommended strong leadership by the Ministry of Health. Others suggested the Secretariat for Social Development act as central co-ordinating agency, monitoring various programs and resolving issues in social policy jurisdiction and legislation.

Recognizing many co-ordination problems relate specifically to care for the elderly, one group recommended a single ministry take responsibility for all long-term institutionalized

services. This would avoid having the elderly deal with a number of agencies to gain access to various services.

Some participants suggested relevant ministries adopt a consultation process, similar to the regional conferences, to encourage communication and co-operation among ministries. Others suggested all ministries be structured in a similar way, internally and in local and regional organizations, with the same geographic boundaries, which would encourage greater co-operation and co-funding of programs. Through gradual and broad policy adjustments, block funding could be made available to reallocate monies for operations, planning and programs within a given region.

Some groups advocated amalgamation of Health with Community and Social Services. Others stressed inter-ministerial co-operation. Those who favored co-operation rather than amalgamation were hesitant about the creation of a "super-ministry."

It was thought certain sections of government might resist efforts to co-ordinate and, in some cases, rationalize services and programs. To overcome such resistance, co-operation would have to be initiated at a high level. One recommendation was the Ministry of Health prepare a "quality of life" mission statement to be endorsed by Cabinet. This would commit relevant Ministers and their ministries to a concerted co-ordination effort.

Some participants suggested Ontario "simplify the system, reduce bureaucracy and develop productivity standards" as a means of improving co-ordination.

Due to the unique situation in the north (sparse population, great distances, unorganized territories) existing care delivery systems may be inadequate. One group recommended an inter-ministerial approach to northern problems. Participants suggested other models of integrative health organization, such as those found in Scotland, Quebec and Scandinavia, may provide more appropriate health and social services in northern Ontario.

**Continuity of care — co-ordination of manpower and programs**

Although lack of co-ordination was identified as a provincial organizational problem, conference participants were concerned also about its impact at the local level. Lack of co-ordination among local health and social service agencies and institutions can result in problems of assessment and placement and threaten continuity of care, particularly for the elderly, children, psychiatric patients, natives and others who cross jurisdictions of various ministries and agencies.

In many cases, problems of assessment and placement occur because consumers and providers are unaware of available services and resources. Delegates recommended the Ministry of Health produce and distribute to relevant agencies and providers a directory of all health and social services available in a community, complete with phone numbers and contact names. (The directory could be similar to the government blue pages in the telephone book.) Such a directory could be supported by a referral/placement system or multi-service centre which would be responsible for helping consumers and providers make contact with required services. One group suggested DHCs develop a community resource and referral agency available to providers and users on a 24-hour basis. Another suggested a "case manager" to guide clients or patients through the system and co-ordinate information among various agencies.

To guarantee continuity of care, local provider groups will have to work together to co-ordinate programs and services, and to establish better linkages between community-based and institutional facilities, particularly in long term care. DHCs could be given discretionary funds to reward agencies which take a co-ordinated approach to service delivery.

Providers are the key to appropriate assessment and placement. To make full, co-ordinated and continuous use of available services, professional training should be multi-disciplinary. If providers are aware of various skills and resources of allied professions, they will be more likely to place patients appropriately.

Participants suggested health and health-related responsibilities be consolidated under a single local group such as DHCs, an upgraded DHC, a District Social Services Council, a Human Services Council, or a network of people and agencies. If the DHC approach is to be used, one group suggested the membership selection process be altered, either through direct elections or indirect representation, to allow for a broader mix of consumers, providers and local government representatives. This would be crucial to better service co-ordination. Regular and mandatory communications between the DHC and local government, providers and institutions would solidify community co-operation. It was suggested community advisory boards could be established to encourage consumer input.

**Co-ordinating future needs and services — planning**

Related to the need for better co-ordination of health-related services is proper and effective system planning. According to conference delegates, effective planning will make the system more responsive to health needs, and help it work more efficiently within limited available resources. To date, a general lack of planning, complicated by professional

parochialism and interprofessional and community rivalries, has inhibited efficient operation of the health care system.

While participants favored a strong central policy and strategic plan for health with basic standards of care set by the province, they were adamant about need for regional and local input. Local participation was seen as a means of guaranteeing that health plans, programs and priorities reflect local community needs.

A number of groups felt "values" should be reflected in planning decisions. Such values should stress "humanized care, quality of life and quality of care." One group noted it may be necessary to decide which health services society is willing or able to afford. Given limited financial resources, a choice may have to be made, for example, between funding dialysis or health promotion. Such decisions would have to be based on long term cost-benefits of each program.

**Co-ordinating local planning – district health councils**

Delegates recommended DHCs, or some local group established for the purpose, co-ordinate local planning efforts and work to involve various community groups in planning for health care. Better linkages should be developed with social planning, research, and welfare councils.

Assuming the province will establish basic criteria for acceptable levels of health, communities should have the freedom to add to minimum levels of services or set priorities in keeping with community needs and available resources.

The role of DHCs should be clearly spelled out and councils might have veto power and adequate appeal mechanisms. Hospitals and agencies could submit a mission statement to DHCs for their consideration.

Communication between various planning regions and the ministry could be improved by making one person in each area responsible for communication of regional planning priorities. Based on their knowledge of local needs, district health councils should also take responsibility for rationalization studies and decisions.

DHCs, instead of Queen's Park, should become the focus for local special interest lobbies. Councils are better able to judge the merits of requests from these groups.

According to some delegates, planning areas should be organized from the planning district level up, linking districts within regions. Organizational boundaries for the OHA, OMA and other groups should correspond to those of the ministry.

In general there was widespread support for the DHC concept. Many participants said DHCs should have more responsibility and more "clout" or power delegated to their level. Several groups requested the ministry develop DHCs in those parts of the province not currently served by one. Others suggested DHC responsibilities be expanded to include advocacy as well as planning. DHCs should also work to maintain a more co-operative planning environment.

**Supporting planning – data and evaluation**

Need for a complete, accessible data base to support planning was mentioned by a large number of groups, as was a request for planning methodology and program evaluation techniques.

To support more effective planning, the ministry should continue to set standards for care and training while using local and regional input to develop long term goals for the system. Delegates stressed the need for a strategic plan for care for the elderly, and requested elderly be involved in the planning process. Boundaries for planning regions should be reviewed. Central, co-ordinated data should be made easily accessible to those involved in health planning. According to conference participants, decision-making should be rationalized through use of a common data base, performance indicators, priority program lists and information on needs and gaps in service. Once implemented, all plans should be monitored and evaluated and results fed into the data base to support planning in other communities and regions.

## Decentralization

Desire for local input into planning raises the subject of decentralization. Because it had been a strong theme at the Minister's Policy Conference in April, the concept of decentralization was presented to regional conferences in background papers. Data generated by regional conferences indicate decentralization may have been a forced issue, or one which may not have arisen had it not been specifically presented for consideration.

There was strong, widespread support for decentralized planning, and some support for decentralized management, implementation and evaluation of health programs within provincial strategy guidelines. On the question of decentralization of fiscal and executive authority, however, opinion varied. Twenty-one of 37 groups at regional conferences did not see decentralization as a major issue and preferred to focus discussions on other matters. Five groups supported fiscal decentralization, arguing it would make the system more responsive to local needs; five groups rejected fiscal decentralization, fearing it would create another costly level of bureaucracy and make budget decisions subject to local pressures. Some who opposed fiscal decentralization cited examples of the ministries of Community and Social Services and Education, suggesting their experiences with decentralization had not been entirely satisfying or successful. Six other regional groups discussed fiscal decentralization but did not reach conclusions.

Several groups suggested, instead of decentralizing power and decision-making from government to the communities, the system work to generate ideas at the grass-roots level and feed them into the system, thereby having a greater impact on planning and change.

### Decentralization of fiscal authority

Those who favored fiscal decentralization suggested a variety of possible approaches. Some groups suggested DHCs, or an elected body, could exercise fiscal authority for a region, while others felt DHCs, as they are presently structured, are unable to handle fiscal authority. The Ministry of Health could assign local budgets globally and set minimum standards, with a local body allocating resources.

Consistent with desire to have a health care system responsive to local needs, one group suggested selective decentralization which would "encourage mutual planning based on trust, communication, consultation and respect." Greater fiscal authority at local levels may require built-in evaluation mechanisms to ensure accountability.

One group recommended Northeastern Ontario be a pilot project for a concept it called "the Regional Council." Authority for the council would have to be legislated, with its structure determined through research and consultation with health care providers and consumers. With jurisdiction for a population of approximately 800,000, the regional council would be responsible to people of Northeastern Ontario and to the funding source. Standards and legislation would remain provincial responsibilities. DHCs would continue to act as advisory bodies to the regional council. The council would re-deploy existing resources, simplify manpower projections by relating them directly to regional needs, develop affiliations with a health science centre in Southern Ontario, increase potential for self-sufficiency in tertiary care and expedite decision-making.

Desire for fiscal decentralization in Northeastern Ontario reflects the view that the north, unique in many ways, knows what is best for the north. One group questioned this assumption, however, and argued there is no "northern" identity. The region is characterized, instead, by disparate needs and much competition. Whether those needs would be best met by centralized or decentralized fiscal control still remained a point of discussion.

In general, participants in the northern conferences were very hesitant about endorsing fiscal decentralization.

**Decentralization – shared authority**

In an effort to resolve central and regional control over funding, one group suggested DHCs not have fiscal authority, but shape funding in their districts through budget reviews and advice to the ministry.

Among those favoring decentralization, there was concern about implementation. Some noted they did not want decentralization to limit leadership and advocacy of a strong Minister of Health. Given strength of feeling among those opposed to fiscal decentralization and the cautious approach of those in favor, it was suggested the ministry would be wise to move slowly and carefully in this area, exploring the concept and testing fiscal decentralization through pilot projects before making any system-wide move.

## Community-based programs and alternative delivery systems

Conference participants clearly indicated their belief that community-based programs and alternative care delivery systems would provide less costly alternatives to institutionalized care, more individual-oriented care, and additional back-up or support services for institutions.

Other delegates noted community-based programs, which would have a "neighborhood focus" and therefore be less threatening, may allow the system to meet needs of special groups such as the elderly, chronically ill, ex-psychiatric patients, women, natives, adolescents with mental health problems and ethnic groups. In small or remote communities which do not have hospitals, community-based alternatives may ease problems of access to care.

Alternative delivery systems would take some aspects of health care out of isolated, professional, institutional settings and put them into the community which would, in turn, encourage more community involvement in health care and make better use of available professional and volunteer manpower.

Consistent with desire for local input into health programs, the province could establish guidelines for community-based care, with planning and development done at the local level.

### Developing community-based care — programs and education

For community-based programs to offer a real alternative to traditional hospital-based care, the system will have to develop effective programs and then educate both consumers and providers about the quality and value of those programs. If people are to be persuaded to use community alternatives, education will be crucial. "We have taught people how to use the system," one group noted, "but not when to use it, and not which part of it to use."

As an illustration of how to make more appropriate use of the system through less costly alternatives to hospital-based care, and of how to address a specific problem of system abuse, one group looked at 24-hour care. Community clinics staffed by health professionals (not necessarily physicians) should be accessible 24 hours a day. The service should be advertised through pamphlets, counselling, television, health professionals and their organizations. Consumers who made less use of services could be given a rebate for health; those who used services appropriately would receive care at no cost to them; and those who persisted in using hospitals emergency rooms, instead of the clinic alternative, would be charged what one group called "mis-user fees."

Although community-based programs would provide alternatives to hospital care, they should not compete with hospitals. In

some cases, community-based or outreach programs could be developed and staffed by hospitals themselves. This view was particularly prevalent in smaller centres where hospitals have been the focus of health care delivery.

One group discussed "the community as the theatre of operation" in which people and agencies form a network of mutual responsibility, providing service on a spectrum from positive health to illness.

In terms of actual programs, home care, particularly for the elderly and disabled, community health centres, health services organizations and support services for deinstitutionalization were strongly endorsed. These programs should be expanded. Noting the current system tends to stress acute care, a community-based assessment and placement resource, available 24 hours a day, should look more carefully at alternative forms of patient care. Multi-service or socio-health centres would co-ordinate social service and health care delivery in each community and provide, as one group phrased it, "one stop shopping."

In addition, the ministry should develop hostels and respite beds, especially in the north where patients and their families are often required to travel some distance for tests or treatment. Hostels would provide less costly accommodation and would free hospital beds for those who need them. An active paramedic program in remote areas could be an effective alternative to hospital-based care.

Respite beds, day hospitals, meals-on-wheels, wheels-to-meals and holiday relief programs were recommended to provide support for those caring for elderly or disabled people in their homes. The ministry should expand home care to include homemakers who do not have minimum service requirements, but maintain home care standards and monitoring systems. Eligibility criteria for chronic home care should be examined to determine whether it is an alternative to extended or residential care. In one group, support for home care was so strong that it recommended the ministry freeze construction of nursing homes, particularly profit-making homes, except in needy areas and redirect funds to home care programs.

Other community-based and alternative programs could be established in the workplace in co-operation with the private sector. (These suggestions are discussed in more detail in the section on health promotion.)

**Manpower for community-based programs**

Provider education was identified as a priority for establishing effective community-based programs. Providers should be knowledgeable so that they can, in turn, educate people who come to them for advice. One group suggested one physician in each community be put on part-time salary to

provide information on available health care services and to assess and place patients in appropriate programs.

More effective use should be made of other health professionals or, as one group put it, health care should be "de-medicalized." Nurse practitioners should be licensed to perform some duties now limited to physicians. This licensing change would help improve access to care, especially in certain parts of the province, and provide less costly, but still efficient and effective, alternatives to the present physician-oriented system. A number of other health professionals could also play a stronger role in provision of care and an interdisciplinary team approach to health care should characterize community-based programs and make best possible use of manpower resources.

Consistent with the desire for a holistic approach to health care was the recommendation that professional education stress an interdisciplinary team approach to health. If providers are more knowledgable about skills and practice provided by allied professionals, they will be more likely to make use of those skills when placing patients in care.

To support provider and consumer education, an inventory of community-based programs should be undertaken. Participants suggested many alternative services are currently under-used because people simply do not know of their existence.

**Supporting community-based programs: funding, incentives, volunteers, data**

Certain incentives could be used to encourage development of community-based programs: tax deductions for volunteer time; tax breaks and other support services for those caring for people in their homes; and financial incentives to persuade hospitals to develop outreach programs. Recognizing lack of funding for allied personnel is now limiting their roles in alternative delivery systems, participants suggested the OHIP Schedule of Benefits be revised to allow for direct billing from nurse practitioners, nurses and other professionals who could be directly involved in delivering care through community-based programs.

On the issue of funding the suggested shift from institutional to community-based care, one group noted community care is not necessarily cheap and start-up costs may be high. Consequently, some seed or transitional funding will be needed. Although groups advocated a shift from institutional care, it will be necessary to maintain institutional services for those who need them. Funds could be shifted from institutions to community-based programs. A very small percentage shift would drastically increase funding available for alternatives. It is expected less costly community-based services will eventually reduce demand for hospital facilities

and services and thus free up money within the system to be reinvested in new priority programs.

To defray costs of establishing community-based programs, facilities such as vacant school buildings or available hospital space could be used. Some groups stressed community-based programs should be a "care concept" rather than a building, and should not require capital building costs but rather make more efficient use of available resources.

In addition to reallocating funds and manpower within the system to support community-based programs, communities themselves could raise money for programs they wanted. The ministry should recognize community-based programs require heavy volunteer commitment and should take advantage of the currently untapped resource of volunteers in the province. Volunteer manpower could dramatically cut funding levels required for certain programs. The elderly were specifically identified as a competent, qualified volunteer group.

To promote careful and informed program development, community-based programs should be monitored and evaluated and data made available for planning purposes. Specifically, the ministry should study funding mechanisms for in-patient and out-patient services to encourage hospitals to make better use of beds.

## Accessibility

Although a universal and accessible system is a basic principle of health care in Ontario, participants identified some difficulties with access.

Some groups recommended consumers have 24-hour access to physicians or to care, though not necessarily through hospital emergency departments.

Much discussion focused on physicians as the only point of entry to the system. Some groups felt this limits access, and suggested other professionals, such as social workers, nurse practitioners, public health nurses, nutritionists and so on, become accepted points of entry. Others suggested physicians remain the only point of entry, but referral and placement services be improved and an interdisciplinary approach to care be encouraged.

Central to the concept of access to appropriate types and levels of care is an emphasis on co-ordinated assessment, referral and placement services.

Other specific recommendations fall into four categories.

- Geographic inaccessibility
- Functional inaccessibility
- Financial inaccessibility
- Over-accessibility and abuse

### Geographic inaccessibility

In some areas of the province, the system still seems geographically inaccessible due to distance from facilities, lack of transportation, and/or shortage in manpower, particularly specialists. This is a particular problem in the north and in small, remote communities. In some cases it is almost impossible to provide services in certain communities. In others it is difficult to attract qualified personnel. In both situations it is usually necessary for people to receive care in other communities.

#### Manpower and information

To ease geographic problems of access, participants endorsed the Underserviced Area Program and asked the ministry to continue to attract qualified manpower to remote parts of the province. Particular effort should be made to persuade specialists to relocate to the north. Conference participants in the northwest and northeast recommended the ministry

establish medical training, internship, residency and placement programs in the north. These programs should be supported with bursaries for northern students because people raised in the north are more likely to settle and work there. The ministry should make access to medical education easier for those in the north. To counter professional isolation, continuing education, exchange programs and similar activities should be instituted. Although the ministry should continue to take responsibility for promoting the north, professional associations such as the OMA, College of Physicians and Surgeons and others should also encourage their members to consider practising in northern Ontario. Any government or association efforts should also be supported by northern communities themselves, which should actively promote advantages of living in the north.

Recognizing there is a shortage of trained manpower in certain parts of the province, it was suggested nurse practitioners and other allied professionals be attracted to those areas and licensed to perform some services usually restricted to physicians. Such a move must be supported by a consumer education program to reassure people they would be receiving quality care.

One group noted that travelling clinics have been successful in bringing physicians and specialists into remote communities. However, patients still have to travel sometimes hundreds of miles to fill prescriptions issued through these clinics. They suggested a mobile pharmacy might ease access to prescription drugs.

Telidon and telehealth were endorsed as positive technological developments which help alleviate geographic access problems. Telehealth, described by one group as a "hospital without walls," has already helped ease access to information. The program should be expanded to cover areas of the province which it will benefit most.

**Transportation and referrals**

A number of recommendations dealt specifically with transportation and referral problems. While air ambulances have improved access to major centres, one group dealt at length with suggested improvements to the service.

One major problem with air ambulance transfers, the group noted, is "ambulance fatigue." Because of regulations about the number of hours a pilot may fly, pilots may not always be allowed to return home immediately and doctors and nurses are often either stranded or left to find their own way home. To counter this, participants suggested ambulance attendants be properly trained to assume responsibility for the patient in transit so hospital staff do not have to travel.

Given that goals for air ambulances should be patient safety and comfort, a family member should be allowed to travel with the patient, particularly if the patient is very sick or is a child. The ministry should review guidelines for use of air ambulance, and for inter-hospital ambulance transfers, and consider volunteer drivers, service club buses, taxis or other means of transportation which may be more cost-effective.

In addition, southern hospitals should review discharge practices for northern patients. According to participants, some northern patients have been discharged in pyjamas, with no immediate means of getting home. Others, discharged as wheelchair patients, have had to walk or be carried onto small aircraft to get back to their communities.

There was some question about air ambulance funding. Could funds be used more effectively to establish care within remote communities? STOL aircraft, which can carry more equipment, patients and attendants, might be more efficient than airplanes and helicopters now in use.

A number of improvements to referral patterns were suggested. They included subsidized transportation, hostels and respite beds for patients not ill enough to need air ambulance services or hospitalization. This suggestion highlighted one of the inevitable abuses of the system. In order for transportation costs to be paid by the system, patients must travel by air ambulance and be hospitalized. If a patient is not ill enough to need ambulance service, it is a waste of the service and an extra expense to the system. The system instead could pay for other means of transportation.

### Access in the north

Because geographic inaccessibility is a major problem in northern Ontario, participants spent a great deal of time discussing expectations of the health care system. Recognizing their unique situation, vast distances and sparse populations, northern participants noted it may be unrealistic to expect the same level and kind of service in the north as the south enjoys. Southern patterns may, in fact, be inappropriate for life in the north. Those living and working in the north should develop their own health care models and systems. They should take advantage of a tradition of self-reliance and community spirit, make full use of volunteer manpower and emphasize health promotion.

Northern delegates suggested the ministry should consider testing community-based or innovative programs there.

## Functional inaccessibility

Another access problem was identified as "functional inaccessibility" or inability to use the system because of

barriers such as language, culture or education. New Canadians, natives, members of some ethnic groups and those who are illiterate may be prevented from using the system appropriately simply because they do not understand how it works. Functional inaccessibility can also describe more personal problems faced by natives, francophones or members of ethnic groups who cannot get access to health care in their own language. This communication barrier can limit access to services.

To address problems of functional inaccessibility, professionals should be alerted to difficulties certain groups may have using the system. Natives, francophones, and other ethnic groups should have access to care in their own languages. Participants suggested, for example, every facility in francophone communities have French-speaking staff on duty at all times; more training be available in French; and French-speaking personnel be encouraged to work in communities where they are needed. An inventory and directory of French-speaking personnel might help make better use of available language skills.

### Financial inaccessibility

Financial inaccessibility was identified as another access problem. Although OHIP was originally introduced as a means of overcoming financial barriers to the system, some groups felt OHIP premiums themselves constitute a financial barrier. Others objected to user fees, opting out and extra billing, arguing such practices create a two-tiered system of health care, dependent on a person's ability to pay. For those who have to travel to health services and facilities, cost of transportation and living expenses can constitute another financial barrier.

Financial inaccessibility was a difficult issue for conference participants because it touches on some fairly sensitive rights and practices. There were some specific, and sometimes contradictory, recommendations on how to address these problems. OHIP premiums could be abolished, and the system become totally tax funded. Those who can afford to pay should pay. OMA and ministry representatives should meet to discuss changes to the OHIP Schedule of Benefits that might reduce opting out and extra billing. The system should provide a funding mechanism for those who have to travel and pay living expenses to receive care.

Other possible funding adjustments are discussed in greater detail in the section on Funding and Incentives.

### Over-accessibility and abuse

The fourth access difficulty, discussed primarily at conferences in southern Ontario, is "over-accessibility" or

misuse of the system. Because services are so easily available, at little perceived cost to either consumer or provider, there is a tendency to over-use the system. According to some groups, over-accessibility or irresponsible use of the system is a major cause of escalating costs.

While some Ontarians suffer from lack of access to the system, others either have too much access or use services inappropriately. Nothing restricts or attempts to control how much people use the system, or teaches them when and how to use it.

Participants cited, as one example of abuse, a growing tendency for consumers to take small medical problems directly to hospital emergency wards rather than calling their own physician. Hospital emergency care is much more expensive, and if used inappropriately, hinders the hospital's ability to respond effectively to real emergencies. To counter this abuse and reduce demands placed on hospitals, a 24-hour service should be established in a setting outside a hospital, at a clinic or community centre. Consumers should be educated in how and when to use emergency services, and when to call their physicians.

Another problem is an overwhelming increase in number of tests ordered for patients. At the present time, there are no incentives to encourage providers to refrain from ordering unnecessary tests. Such incentives should be considered. Also, the ministry should audit use of services, such as lab tests and hospital beds, to determine if they are being used appropriately.

Litigation, or fear of litigation, is having a deleterious effect on system use. Providers order unnecessary tests to protect themselves, practising "defensive medicine." The system should deal with the problem of litigation, perhaps exploring some form of no fault insurance.

Groups discussed deterrent fees as a means of controlling misuse or overuse of the system, but were concerned such action might create another barrier to access for some people. Participants favored consumer and provider education, supported with rewards for proper use of the system.

## Funding and incentives

Funding and incentives were discussed as means of supporting and achieving changes participants would like to see in Ontario, such as increased emphasis on health promotion, development of community-based care, and improved access to services.

Although some groups questioned the basic level of funding and claimed the system was presently under-funded, most accepted there are limits to available funds and present levels should be adequate.

### Funding through efficiency, reallocation, rationalization

Recognizing there are, and will continue to be, limits on funds available, groups advocated more cost-effective programs such as community-based care and home care. To prevent costly inefficiencies, the system should encourage more appropriate use of services such as ambulances and hospital beds. Serious study of present funding mechanisms for in-patient and out-patient services was recommended as one means of correcting inefficiencies and encouraging more responsible provision of appropriate care. One group suggested hospitals and physicians be encouraged to use business principles, and the BOND program be extended to allow hospitals to compete in the marketplace.

Noting many recommendations for programs or initiatives will require some seed or transitional funding over the short term, and reallocation of funds within the system over the long term, the ministry should look for economies in the system and reallocate money to priority programs.

While advocating reallocation of funds, however, most participants felt they did not have enough knowledge or information to make specific recommendations about where and how such money would be located and redistributed. Many favored reallocation from the institutional sector to support community-based services but, for the most part, reallocation decisions were left to the ministry.

Evaluation of existing programs might help identify programs which are neither cost-efficient nor effective and which could be cut. The ministry could experiment with a variety of programs for a single problem. Outcomes of each program would be evaluated and resulting data used to determine which was most effective and cost-efficient.

Groups supported rationalization of services as a means of finding money within the system, particularly if there is local input into the rationalization decision. The need for efficient use of available resources was stressed. Noting "rationalization must maintain or enhance existing levels of

service," participants expressed some concern about premature program cuts.

**Alternative sources of funding**

Trying to deal directly with the problem of funding, groups suggested some alternative sources of money for health care such as community groups, private sector, and other government departments and ministries. The Ministry of Northern Affairs and northern municipalities, for example, could contribute to air ambulance and other services in the north. Lotteries were also suggested.

Although volunteers are already active in health care, the system is not taking full advantage of their services. Volunteers could be used to run a variety of programs which could result in better service, at less cost. The "well elderly" were identified as an effective volunteer group not yet fully utilized.

**Funding mechanisms — some suggested changes**

Concern was expressed about current mechanisms used to fund the system. Some groups were concerned about effects of OHIP premiums on the unemployed, low income earners and other disadvantaged groups and suggested their abolishment in favor of full tax funding. One group questioned whether OHIP is, in fact, a form of insurance and suggested it has become a means of subsidizing health care.

It should be noted, however, a large number of participants strongly supported OHIP and felt success of the present health care system is due, to a great extent, to the OHIP funding mechanism.

As an alternative, the system could be tax-funded with services available free of charge to those who require them, but value of health services would be computed, added to income and taxed accordingly. This would provide a "means test" for paying for health care and remove the burden from low income groups. Some group members objected to what they felt was a "sick tax" approach to funding.

Whatever questions or criticisms participants might have had about basic funding mechanisms, they still endorsed the concept of universal health care insurance.

Examining present fee-for-service payments, a large number of participants felt they "encourage volume practice and reward mediocrity." The system makes little effort to acknowledge or reward excellence, or to encourage accountability among providers. The OMA, together with the ministry, should examine current funding mechanisms and revamp them accordingly.

One group objected to another funding mechanism. It pointed to municipal projects such as roads and sewers, which tend to be totally tax funded, while a health facility must raise a certain percentage of its cost before the ministry will contribute its portion. Municipalities should contribute more to health and use the full property tax base to support local facilities.

Some delegates explored shifting the funding base for the institutional sector from "beds" to patient needs which could create a more flexible, individual-oriented system and might lead to considerable savings. This change should be studied carefully as its implications could be "complicated and dramatic."

**Encouraging positive health system changes – incentives**

Incentives were identified as a means of improving efficiency, encouraging healthy lifestyles and controlling system misuse. Incentives should be used to promote community, home, and family care and health promotion. Critical of lack of positive incentives within the system, groups were also concerned about existing incentives and disincentives which "encourage inappropriate use of types and levels of care (over-use of drugs, for example) and over-dependency on professionals and the system." According to participants, the ministry has failed to explore fully the potential of incentives to influence health and health care.

**Incentives for consumers**

Although a number of groups talked about deterrent and user fees to encourage efficiency and control misuse, participants could not agree to recommend them. Although eager for some control within the system, groups were concerned deterrent fees would hurt those with low incomes or lack of knowledge about health care services and would have little impact on those who can afford to misuse the system. After lengthy discussion, most groups favored rewards or incentives over punishment or deterrent fees.

A variety of possible incentives were recommended: tax breaks; lower OHIP premiums and/or lower insurance rates for those who are healthy, who do not smoke or drink and who make limited use of health services; tax breaks to encourage the private sector to undertake fitness and other employee-related health programs; tax breaks, receipts or credits for volunteer work; and tax breaks, or some form of payment, for those who care for the elderly or disabled in their homes.

**Incentives for providers and the institutional sector**

Financial incentives were also recommended for providers and institutions. Monetary incentives could be used to attract francophone and other health workers to northern Ontario. Bursaries for medical training could be offered to students from the north, on condition they return to underserviced areas upon graduation.

Fee schedule payments for health education or health counselling would encourage physicians to promote health with their patients. Rewards for appropriate use of tests and other health services were also recommended. The fee schedule should be broadened to include payments to nurse practitioners, physiotherapists, nutritionists and other allied professions. Such a move would be consistent with the holistic approach to health advocated for the 80s and would encourage physicians to make better use of other health professionals. It would also improve consumer access to health services.

In terms of financial rewards or incentives for hospitals and institutions, the ministry could offer to match funds freed from hospital budgets for priority programs such as health promotion. In addition, funding for the institutional sector should be examined to ensure it encourages best possible use of resources. One group asked for incentives to encourage use of ambulatory care and other alternatives to keep in-patient, acute beds available to those who need them most. Any savings generated through efficiencies should be left with the institution or program, to be spent at the institution's discretion within ministry standards and guidelines. This practice would create a positive attitude towards saving currently lacking in the system.

**Other incentives**

Incentives can also be used to shape the health care system needed through the 80s and beyond. To reflect health priorities, for example, any new or expanded programs could be asked to include a health promotion component in order to qualify for funding.

Noting there is a shortage of community support services for mentally ill and ex-psychiatric patients, one group suggested some incentive to the private sector, such as profit potential in running group homes, might fill this gap.

Some attention was also given to non-monetary incentives, such as holiday relief, respite beds, family support and counselling, day hospitals, day care, linen service, homemakers, transportation, meals-on-wheels and wheels-to-meals.

Less tangible incentives could be offered to volunteers, such as special recognition for service, special training and academic credit for volunteer time. The ministry could give certain volunteer groups responsibility for specific health promotion or community programs and provide funding where appropriate. Volunteer groups would probably respond positively to this trust and responsibility.

Incentive programs should be tested and evaluated to determine effectiveness before they are implemented across the system.

## Data, Research and Evaluation

In the current system, data are often used with no clearly developed goals and objectives, and results tend to be ambiguous. Decisions are often based on conventional wisdom, or political reasons, rather than on solid information. Although certain data instruments are available to decision-makers, such as the Canada Health Survey, Labor Force Survey, OHIP data and so on, they are difficult to access and do not work from a common base.

To address these weaknesses, groups at all regional conferences endorsed the need for a common data base and evaluation of all health programs. A centralized resource centre should be developed, providing information on existing resources, describing health needs and identifying capacity of various services to deliver care. Participants recommended pilot projects and limited testing of all new initiatives, and suggested resulting evaluations and data be made available, in usable form, to support local planning efforts.

One group was specifically concerned about research and development of alternative care delivery systems and asked the ministry assess alternatives at the district level. Pilot projects for ex-psychiatric patients, for example, could be operated concurrently with separate funding designated for research. The ministry should protect existing levels of service while alternatives are developed.

While conference participants endorsed need for change, they did not ask for immediate implementation of expensive programs. Rather, they want a cautious approach to testing and evaluation and implementation of cost-effective programs only. Government should establish standards for evaluation and data collection; data sources should be rationalized to avoid duplication; consultation on data problems should be encouraged; and communication among researchers should also be encouraged.

Consistent with regional requests that planning and programs reflect local needs, programs should be implemented selectively, in areas where they would be most effective and would respond to local needs.

### Data for programs, manpower, priorities

Common to a number of group reports was a call for more needs assessment studies to be performed, for the most part, by district health councils. One group stressed before a community starts a major fund raising drive for new equipment or facilities, for example, the DHC should determine whether the purchase is really needed. Another group asked government support social innovation research.

Priorities for data and information include health promotion, community-based programs and incentives. Resulting material should indicate effectiveness of various programs, including Participaction and other health-related initiatives.

More accurate manpower projections than those currently available are needed. Evaluation of professional education and training should also be a priority.

One group asked for research into specific needs and problems of women in the north, and another requested a review of regulations, arguing what may be effective in the south may limit care in the north.

The ministry should consider use of outside researchers to provide objective evaluation of ministry programs.

The ministry should audit provider usage of services and tests to determine whether they are being used appropriately.

Although emphasis was on evaluation as opposed to research, there was strong indication that a comprehensive, accessible data base is needed to support program planning. Close co-operation among ministries and agencies in collecting and using data would be beneficial.

## Phase two—The future of the process

The strategic planning, consultative, conference process ended a year after it had begun with the final regional meeting held in Sudbury in July, 1983. The Honourable Keith Norton, having succeeded the Honourable Larry Grossman as Minister of Health, affirmed his commitment to the process. He said, "I believe this consultation process...is a strong beginning for opening up new paths of consensus and co-operation among us, and for identifying ways in which we can initiate change and improvement within the health care system."

With publication of this report, the next phase of the process can begin. At Action Centre '83, in September, 1983, Mr. Norton presented a summary of conference findings documented in this report. "A great deal of work, time and effort on the part of a large number of people has gone into this consultative exercise," he said. "We must now commit ourselves to moving the process ahead and not drifting back to re-examine the priorities already identified.

"That part of the process is now complete...we must keep the momentum going."

At the Action Centre conference, Mr. Norton asked organizations which participated in conferences to submit written comments and suggestions on how the second phase should proceed. "I am...asking the health care organizations to submit their advice or recommendations to the ministry," he said. "I would then hope we could embark on a second phase of the consultation process early in the new year."

Publication of this report provides opportunity for feedback on the strategic planning, consultative process. For this reason, the Minister has requested suggestions on how to move forward with implementation:

"From the reports prepared by the conference workshops, and from the comments received on the conference evaluation forms, it is clear that you (participants) wish to continue to share in planning for the future of our health care system.

"I welcome that enthusiasm. I also want to emphasize that your participation in the process implies a willingness to share the responsibility for implementing the proposals which are ultimately accepted. I hope you will be prepared, in other words, to share with the ministry and me, the task of leadership as we now work to strengthen our health care system to meet the challenges of this decade and beyond."

# HEALTH CARE THE 80s AND BEYOND

# APPENDICES

# Appendix A

**Remarks by**
**The Honourable Larry Grossman**
**Minister of Health**

To the Minister's Policy Conference
"Health Care the 80s and Beyond"
Scarborough, Ontario

April 24, 1983

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This is an historical event in the history of the Ontario health care system.

Just about every major health care professional group is represented here at "Health Care in the 80s and Beyond" along with members of the Ontario Council of Health, the district health councils, and from the provincial Ministry of Health.

As host of this conference my objective is to involve this entire community -- government officials, health service providers, and consumers -- in defining for ourselves the kind of health system that we believe is both necessary and affordable through the 80s and beyond, and in deciding just how we can go about achieving such a system.

But why this elaborate consultative approach to achieve those objectives?

The short answer is that you have the expertise in how to design an appropriate system of services, and that you have said consistently over the years that you wanted to be involved in the development of health policy.

From my point of view, as the Minister of Health, it is essential that we go through a process like this one where we all sit down -- with our individual bias' clearly on the table -- to hammer out a consensus on where we ought to go, and how we are going to get there.

Such a process -- if it is to work -- must involve us in openly examining each others' initial position, abandoning our individual narrow self-interests, and ultimately finding the common ground upon which we can move forward.

I think it is valid to say that too often, in the past, each of us has been too pre-occupied by our own specific interests to look realistically at the needs of the system as a whole.

We can be a very competitive group, and indeed, a fairly combative group. And we have all skillfully learned the art of media relations, public relations, lobbying, and pressure politics.

But it seems at times, that the "system" does not operate as a system at all, but rather as a series of self-perpetuating and competing sub-systems.

Every element of the system has acted, at some point, in terms of narrow self-interests.

Some hospital boards come to me and argue for more high technology for their medical staff, or for a CAT scanner just like the one at the hospital across the street, or for money to pay off deficits incurred because they added several unapproved new programs.

Then, on a philosophical note, those same hospital board members will talk about the need for better co-ordination of long term care services in their community and, yes Minister, we really should get moving on some of those health promotion ideas, if you'd just find the funding.

Members of the medical profession will approach me at meetings during my visits around the province and talk about user fees. "The public misuse the system" some of them will say "so what we really need are user fees to stop the abuses".

The assumption here is that a doctor can't tell a patient that they don't need their services. That's government's job, they say -- through the use of user fees.

Chiropractors, optometrists, dentists, pharmacists, social workers, nurses, and a whole host of other health professionals will come to the Minister's office to argue for an expansion of their "scope of practice;" or to tell me the reasons why we should not allow some other group to encroach on their territory -- or on their right to bill.

All of these arguments are carefully couched in terms of "protecting the patient" -- without reference to any data that may prove their case.

The fact is that during my first few months as Minister there was little -- extraordinarily little -- dialogue about the nature of the system, about what we <u>ought</u> to be trying to do, or about where our emphasis -- and our resources -- ought to be.

Instead, there seemed to be an expectation that the Minister of Health should act as some sort of political arbitrator between interest groups competing for a limited amount of the public pie.

And when hospitals told me they needed money to cover deficits; or when the providers asked for more funds to develop additional programs -- or to obtain higher incomes -- and I asked where I was supposed to find that money, I was told, in effect, "That's your problem. You're the Government."

Looking back historically, it's probably fair to say that the system itself may have inadvertently encouraged exactly this kind of behavior. There are virtually no mechanisms in place to permit consultation between the ministry and the system except on a one-to-one, vested interest vs. vested interest basis.

We've managed to institutionalize our relationships with an elaborate system of professional lobbyists, associations, briefs, counter-briefs, negotiations, and confrontations.

But that atmosphere of controversy and "crisis" that we sometimes create really betrays the reality that we are talking about making adjustments to one of the finest health care systems in the world.

But by and large the groups who are perceived to have the most power are the ones that do the best job at association politics.

But the system just can't operate that way. Or that least it can't operate in the public interest that way.

So we've tried to change that. We've tried to start a direct dialogue with as many people and groups within the system as we can.

We've spent a great deal of time with the key participants in the system -- the Ontario Medical Association, the Registered Nurses' Association of Ontario, the Ontario Hospital Association, the colleges, the providers' professional associations and others.

And I have also spent time with groups who were primarily concerned about quality of care for the elderly, or who were concerned about the plight of the ex-psychiatric patient, or about improved medical education, patients' rights, and illness prevention.

And on the basis of the many conversations I had with people throughout the system I reached four basic conclusions.

First -- I realized that there is pressure for change within the system, but that pressure is blocked because we were not all -- in a consistent way -- looking at the system as a whole and deciding where it ought to move.

Second -- I concluded that there was a real need for a forum to permit all of the groups involved in the system to participate in the responsibility for future decisions -- on a multi-lateral basis, instead of a series of bi-lateral presentations to the Minister.

Third -- I concluded that your participation in that responsibility had to take into account the inescapable reality of the financial constraints that exist -- as I must take it into account.

Fourth -- I decided that no Minister of Health -- and no Ministry of Health acting alone -- could implement all the necessary solutions in isolation.

And so I began asking some questions to a plethora of interest groups. I asked what was good about our system -- because I am firmly convinced it is among the best health services systems on the face of the earth.

I asked what needed changing in the system -- what extra capabilities or extra kinds of responses did we need? What new perceptions did we have to develop?

And I asked, how do we go about making those changes, building those capabilities, and coming to share those perceptions?

What we did was organize three Minister's policy conferences to precede this one. And between those conferences, I met with over 80 different groups to discuss the challenges facing the Ontario health care system.

And I am pleased and proud to be able to tell you that every group that I encountered throughout the system responded positively to those initiatives.

Every group -- in those kinds of forums -- demonstrated a willingness to look beyond their particular vested interests to the shape and the future of the system as a whole.

And I believe that we may already have the basis for a far broader consensus about the kinds of changes that should be made than most of us would have thought possible.

From those first three non-public policy conferences, and indeed the briefs that you have submitted for this conference, we have already reached some minimum areas of consensus.

We have agreed that -- while we have an excellent system in place -- the pressures on the system require us to go beyond simply trying to maintain the status quo.

We must, instead, attempt to implement prudent evolutionary reforms and guide some structural adjustments within the system.

And so throughout this conference, I would hope that we can take the next steps -- based on our discussions -- and start to tackle some of the hard and practical questions that have to be answered in order to translate our beliefs into action.

I won't pretend to you that the published briefs show total agreement about all aspects of the system, or of all ideas on the kind of direction we should be striving for.

There are legitimate disagreements still. And I would say to you, as we begin this conference, that we will not resolve all -- and perhaps not even many -- of those issues here.

But if there are some disagreements reflected in the briefs you submitted, there is also a deeper and broader consensus among you than I frankly expected.

As I read through your opening positions I noted that:

- there is a consensus about the need for an overall long term strategic plan that will permit all parts of the system to work effectively together to reach clearly identified shared objectives;

- there is a consensus about the need for us to move from a narrow focus on illness, into a broader and more pluralistic approach to the promotion of health;

- there is a consensus about the need for better links among all of the elements, skills, professions, and interests in the system; and,

- there is a consensus about the need for a more pluralistic approach to the provision of health services -- about the need for a system that can combine excellent medical care, excellent institutional care, with broader and more flexible forms of community-based services for our citizens.

But perhaps most importantly, these briefs, and the series of consultations that we have had, reveal a renewed willingness among all parts of the system to look critically at our own vested interests, to see beyond the walls of our institutions or the confines of our various disciplines.

You have begun to ask, and to seek answers to, questions that have been avoided in the past because they were believed to be too difficult, or too controversial.

Now -- just how do we go about translating that developing consensus into action -- into pragmatic measures for effective change within the system?

Well, we have to start by dealing frankly with the financial reality -- the inescapable financial reality -- that exists.

And that reality is that, although we can be confident that Ontario will continue its support for health services at current real levels, the public does not have the economic capacity to invest massive amounts of new money into the system.

The public has already been asked for a great deal for our health care system in a period of national economic recession.

The Ministry of Health's budget, over the past three years, has grown by 58 per cent. And that represents a 22 per cent increase over and above the legitimate growth in the consumer price index.

That 22 per cent investment -- above CPI -- equates to an expenditure of some 1.4 billion additional dollars by the taxpayers of Ontario on their health care system.

And that's a substantial contribution by the public when you consider that, during the same period, they have had to shoulder the burden of a national debt that has gone from $11 to $31 billion, and a national unemployment rate that has soared from 6.5 per cent to 12 per cent.

As someone who is accountable to the public for the way you and I spend their money, it's important that we look closely at just how we spent that 1.4 billion additional dollars over the past three years.

And when you examine those expenditures you'll find that while a third of it went into addressing some of our priority concerns -- like mental health, emergency services, care for the elderly, and home care programs -- two-thirds of it went to cover income increases in the health sector; increases in the number of doctors and institutional health care workers; and to cover the explosion in costs for the utilization of drugs, x-ray, and laboratory services.

And when you stop and think that 80 per cent of the total cost of health care system is on incomes; that those incomes have increased at a higher rate in the health care sector than in private industry; and that there has been a 10 per cent growth in manpower within the medical profession and in institutions during a period when our population only grew by two per cent; then you must address the issue of whether the critical health services needs of the system are being underserved at the expense of lower priority items.

And so as we talk about the future, we must understand that we are talking about ways in which we can use our existing resources more effectively.

We must understand that we are looking at trade-offs. And we are looking for maximum public benefit for the dollars we spend.

So when we look at each expenditure -- whether it is on an existing service, or for the development of new services -- we must all ask, "What else could we be doing with that money? Is there some other way in which it could be used more effectively or more creatively?"

When you look at our total spending on health care -- at $6.8 billion -- or at just the hospital component -- at $3.6 billion -- and you think, if we could just use one per cent of those resources -- some $68 million ... or $36 million -- what else could we achieve in the health care system?

How many home chronic care programs could we establish? Or, what kind of renewed mental health care system could we put in place? And how much would those kinds of programs -- by complementing hospital and other existing services -- add to the effectiveness of the system?

At present, only some 3.3 per cent of the ministry's total budget is allocated for community health services. And yet, every group in the system has called for more and broader activities in health promotion, and for more community services.

What kind of a community-based health care delivery system could we have put in place for the amount of money we spent this year just addressing the base budgets of hospitals?

I know very well that many of you don't feel all that comfortable being asked to look at the future of the health care system within the confines of budgetary realties.

It's not easy. And besides, "It's supposed to be the job of politicians to make courageous decisions."

But if this process of consultation is to be more than an exercise in writing wish-lists, we must <u>all</u> start to look at those practical questions. We must all be courageous.

We can't just say "It's up to the Minister of Health to find the money," because ultimately he must get it from the taxpayer -- in whatever form -- and that comes down to the question of affordability.

I believe that it can only be done if both you and I are willing to be courageous and creative in our attempt to serve the broader public interest.

Since we already have reached some degree of consensus on many of the directions for change that we should be pursuing, I would hope that we can also begin to deal with questions of resources -- without narrow efforts to keep our particular ox from being gored.

And I hope that at this conference we can discuss the major issues facing the health care system in a co-ordinated and integrated way.

Let's talk about quality of care. Let's talk about it in terms of the services to the elderly in our chronic hospitals, in our nursing homes, in our homes for special care, and in our communities. And, how do we achieve a continuum of care?

Let's talk about real implementable strategies for health promotion and illness prevention. How do we make this a real target, and more than just an advertising campaign?

Let's talk about the role of hospitals. Let's discuss ways in which we can increase productivity and break down the "bricks and mortar" mentality of some institutions by developing more community outreach programs.

Let's talk about co-ordinated manpower planning for health care. Let's discuss it in terms of what we really know about each profession's "scope of practice" and what is really in the public interest.

Let's talk about the OHIP system and the fee schedule. Is it based on health priorities? Does it reflect what the profession tells us about the efficacy of some medical procedures? Does it reward the kinds of practice patterns that our physicians say are more appropriate? Does it reward excellence?

Let's talk about primary care and how we could make it the focus of our strategy for the 80s and beyond.

Let's discuss how we can rationalize emergency services for accident, heart attack and rape victims in ways that will allow us to deliver improved regional services.

Let's talk about the introduction of high technology and its impact on the system. How can we manage it, rather than have it manage us?

Let's talk about community-based programs and their appropriate role within the total system.

Let's talk about developing alternative systems of health care delivery. In what ways can we develop appropriate rewards for prudent behavior by practitioners, consumers, and administrators?

Let's discuss the system's effectiveness in protecting the public interest. Are there some ways in which we might improve the perceived role of the colleges?

Let's talk about medical education and if we are currently turning out the kind of professionals that we need in the 80s and beyond.

Let's talk about co-ordination of services. How do we stop the senseless competition between hospitals? How do we develop better linkages between our institutions and the developing community-based programs?

Let's talk about the mental health care system and the role there might be for a larger community-based component and the pivotal hospital concept.

Let's discuss the utilization of x-ray and laboratory services. How do we encourage health care providers to practise in a cost-effective manner?

Let's talk about the areas within the system where greater efficiencies might be realized. How can we shift resources from one area to another? And, are our existing funding mechanisms appropriate?

But when we talk about each of these issues, we must deal with them -- not as a series of isolated discussions -- but in terms of a fully integrated approach to the system as a whole.

And we must address them, as well, from the perspective of the economic capacity of our citizens to fund the system.

I firmly believe that our health services system <u>is</u> adequately funded -- in total. I also believe that there are areas that do require additional funds and areas that require some expansion.

But we are a fairly creative group and I'm sure that we can, together, come up with ways of finding the resources -- within the existing system -- that are required to shift our current orientation.

Let me illustrate my point with two examples.

We've all basically agreed that we should increase our efforts on health promotion/illness prevention and we've agreed that while we should maintain and enhance our excellent range of institutional services, our future focus should be on the development of a viable community-based services component.

So how do we achieve those goals?

Well, in terms of the health promotion strategy component, perhaps we could provide appropriate incentives within the fee schedule that would encourage that type of orientation in a whole range of areas.

That, of course, would cost several million additional dollars to OHIP -- unless the government and the medical profession agreed to shift funds within the total fee schedule budget.

For example, are there currently procedures within the existing fee schedule with questionable efficacy, or on which we may have inappropriately placed too high an economic incentive?

If that is the case, we can indeed fund new health promotion and illness prevention programs -- like the teaching of proper nutrition and proper weight control -- by agreeing to shift resources to the other areas that more accurately reflect health needs.

In the past, there has been a very simple reason why we could not do this. There has been so little trust, so little shared sense of purpose between the ministry and the providers of health services that any suggestion of altering fee schedules, or studying practice patterns, would have immediately been perceived as a government effort to interfere in the practice of medicine.

Any action by government has been perceived to be simply another way to save money.

But I hope we are beginning to put that kind of attitude behind us now. I think we are beginning to see that we have to be able to talk about these kinds of questions. That we in fact share a mutual concern: the health of patients.

My second example of how to find resources to fund new priorities relate to community-based services.

We have, in your briefs, calls from virtually every group participating in the process, to develop more flexible ways of providing services at the community level.

We have, as well, clear urgings from the OMA in their brief to encourage a more pluralistic approach to the practice of medicine -- to encourage the development of a broad range of choices for both patients and practitioners.

And we have briefs submitted from the hospital community which call for the expansion of home and community services as alternatives to institutional care.

There are many ways we can deliver community-based services. One such mechanism is the community health clinics and health service organizations.

But currently only about two per cent of the population have access to services delivered through these vehicles.

I think we all agree that if we are to really achieve the pluralistic system we talk about -- with alternative competitive models available -- then this component of the system must grow in the years ahead.

And I think that we should all agree that a system that is truly pluralistic -- one that permits a certain degree of opting out and extra billing at one end -- can also benefit from an expansion of these alternative forms of practice at the other end.

But if we do all agree that there should be an expansion of CHCs/HSOs -- and the other forms of community-based services -- where will the money come from?

Can we not begin to talk about building these services, if necessary, with funds that could be re-allocated from other parts of the system?

And could we not talk about the special support hospitals could be offering to develop better linkages -- like day hospital programs, co-ordination and assessment programs and community outreach programs -- that currently have a lower priority than, for example, the expansion of high technology within our institutions?

Each of these questions -- had we asked them openly a year ago -- would have sparked an immediate controversy, and an immediate negative reaction from some quarters. Not so, perhaps, today.

True, some might still find these sorts of questions unsettling, but I believe we have established enough trust, enough sense of shared purpose, to be able to begin to answer these and other difficult questions now.

I believe we must.

And I believe it is critically important that we begin to find the answers that will permit us to allocate resources within the system and that will enable us to afford the new capabilities that may be more appropriate to the needs of the 80s and beyond.

If we cannot, through this process, begin to deal with these difficult questions, and begin to find hard and practical answers, the need for change -- for a re-focusing of the system -- will <u>not</u> go away.

It will merely intensify.

But we have a chance now -- here at this conference -- to define the changes that are needed, and to reach a broad agreement about the kind of system we want, and about the trade-offs required to obtain it.

If we waste that opportunity, if we return to defending narrow vested interests, if we refuse to tackle the difficult issues or if we just carry on business as usual, then I predict with some certainty what will happen in the future.

Eventually some federal or provincial Minister of Health will simply legislate some desperate changes at the eleventh hour.

It won't work nearly as well, of course, because without consensus our system cannot change without severe disruption. It would not be very pleasant for anyone to have Draconian top down measures that would, no doubt be -- by their very nature -- blunt, across-the-board, centralized, and unfair.

I believe it would be tragic.

But it will be necessary if we fail in the venture we are embarking on today -- the challenge of building a health services system that will take the many excellent features that already exist, and enhance and preserve them, while adding the new forms of service delivery, and the orientation to health promotion that we all agree are needed.

I am optimistic enough to believe that we will <u>not</u> fail.

I am optimistic because of the progress we have already made -- because of the consensus that is already developing, and because of the growing belief in the sense of shared purpose that exists here today.

Of course change is never easy. It is never comfortable. But it can be tremendously rewarding and exciting.

Over the next three days at this conference -- and in the months ahead as we continue a process of consultation and planning for the future, I hope that we can all share in that sense of purpose, and in the sense of achievement that will lie at its end.

I said at the beginning of this conference that "Health Care in the 80s and Beyond" is an historical event.

We have gathered together to re-examine what we all believe is already one of the best systems of health care in the world.

But it is our collective responsibility to move that system forward -- to improve upon it where we can -- to rationalize it, to modernize it, and to re-adjust our priorities to meet the needs of the future.

I have said before that I hope we will approach this task with the sort of open-minded attitude that says, "Let us identify those things that are valuable and good, so that we may maintain and reinforce them; let us identify the things that are weak, so that we may either strengthen or replace them; and let us identify those things that are harmful or counter-productive, so that we may correct or eliminate them."

That is the task that we have asked you to share with us.

Our success depends on your active and direct participation in this vitally important process.

I expect each of you to show the kind of courage in dealing with your own vested interests, your own associations, and your own membership as you expect politicians and Ministers to show.

We in government stand prepared to make the appropriate adjustments to the system -- are you?

# Appendix B

**Remarks by**
**The Honourable Keith C. Norton**
**Minister of Health**

Action Centre '83
London, Ontario

September 15, 1983

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As the Minister of Health, I am very happy to welcome you to the ninth Action Centre conference of district health councils. I know Action Centre has been an annual event since the district health council program was inaugurated in the mid-'70s. It has served as a valuable forum for council chairmen, members and staff from across the province to share experiences, exchange ideas and strengthen the commitment to our province's health care system.

Having held the health portfolio for just over two months, I will tell you that I am looking forward to building a close working relationship with all DHCs.

As district health council members, you are close to the people the health care system serves. You are in a position to assess their needs, take stock of existing resources and help to determine the priorities for the evolution of health care in your communities.

There is, quite likely, a mood of anticipation at this event -- a feeling that this year's conference is perhaps one of the most important in some time.

The fact is, district health councils have just completed what I hope has been one of the busiest and most fulfilling years in their history. At this conference you will be reviewing the achievements of the past 12 months, and looking ahead to focus your energies on the tasks that lie ahead.

It was at this conference a year ago that my predecessor, the Honourable Larry Grossman, announced the creation of a strategic planning process for Ontario's health care system. DHCs responded to this undertaking by hosting six regional consultation conferences across Ontario.

Let me affirm at the outset that this process of consultation and planning is one which has my unqualified support.

But first I want to express the ministry's appreciation to district health councils for their contribution in three other areas: your review of mental health services in the communities, the studies into regional emergency health care needs and your participation in the developmental assessment study.

Regarding this last project, I am looking forward to receiving feedback from DHCs by November 1 on the developmental assessment report which is now in your hands.

Tonight, I especially want to convey my appreciation to district health councils and the Ontario Council of Health for their support and assistance in organizing the recent series of regional policy conferences. In particular, may I thank and compliment the six councils who hosted conferences on behalf of the six regions: namely the councils in Thunder Bay, Ottawa-Carleton, Thames Valley, Waterloo, Metro Toronto and Manitoulin-Sudbury. This exercise called for an enormous amount of work above and beyond your normal tasks and my ministry recognizes the fine effort you put into the plans and preparations.

The consultative process was initiated in order to come to grips with a series of social and economic challenges -- trends which if left unchecked could threaten the quality of health care we have come to expect in Ontario.

One obvious challenge is financial. The budget of the Ministry of Health has grown 50 per cent in the past three years to its present level of $7.5 billion. That rate surpasses inflation by 22 points over the three-year period and represents real growth in health care spending of $1.4 billion.

Other forces that are now bringing about change are just as well known to this audience. Our population of elderly people, for example, will grow by half a million by the end of the century -- intensifying the pressure on health care resources. And new medical technologies and procedures are generating new demands and expectations by creating new therapies and diagnostic procedures.

In the political arena, the federal government's proposed Canada Health Act and the federal-provincial debate over health care funding are additional pressures for change. In more general terms, consumers now widely expect to participate in decisions that affect them. And the growing interest in pursuing a healthy lifestyle has become a permanent feature on our social landscape.

To navigate through these winds of change, the ministry last year initiated a process that would address the conflicting needs, problems and pressures -- a process that would eventually lead to a carefully reasoned, long-term strategy for the health care system of Ontario.

But it was clear that the Minister could not act in isolation to shift the direction of a system as complex as health care. The active participation of all those directly involved in the operation of the system -- both providers and consumers of care -- was seen to be essential for both planning and implementing any reform process.

To prepare for the consultative exercise, a small group of senior ministry people, community representatives and Ontario Council of Health members met in July 1982 to consider broad options for managing Ontario's health care system.

It was agreed that neither the ministry nor those active in providing health care could afford to carry on as they had in the past -- constantly adjusting and adapting the system on an ad hoc basis in response to crises.

Instead, the ministry was urged to begin a broader process of evolutionary reform -- to realize gradual change based on careful, long-range planning.

The next stage was a larger meeting of individuals from the ministry and its advisory bodies plus invited health care experts. This group convened last September to begin to develop a strategic plan. As a first step, the meeting identified possible obstacles which could hinder change -- such as a focus on treating illness rather than promoting health, and the rivalries which can exist between various provider groups and institutions.

Then representatives of the three major provider organizations -- the hospitals, doctors and nurses -- attended a conference last February with ministry executives, Council of Health members and health care analysts. This gathering fully endorsed the strategic planning process.

During this time, the ministry invited a number of organizations to file briefs outlining their views on the future shape of the health care system. I would like to thank all of the professional societies and health care associations who co-operated in preparing those background papers. They required a good deal of time and effort and I am sure they were an invaluable aid for reference on policy issues.

These papers were compiled in a background document for the next stage in the process -- the Minister's Policy Conference at the Ramada Renaissance Hotel in Scarborough.

Two hundred forty people representing 60 different government, professional, consumer and special interest groups throughout the province attended the three-day conference last April.

As interpreted by the Ontario Council of Health, the delegates made the following assessment.

First, Ontario's health care system has major strengths. It is highly rated by the public, it is evolving toward deinstitutionalization and community-based services, it is an accessible system, and it is managing costs reasonably well. While such praise should not make us complacent, it does emphasize the context for any planning effort: the objective is to build upon and to improve what is already as fine a health care system as exists anywhere.

The April conference then went on to identify the weaknesses in the system. For example, co-ordination and continuity of care were perceived to need improvement. To an extent, financial, geographic and other barriers to access were found to exist. The system was considered relatively inflexible because of its centralized nature. And the absence of strategic planning, the misuse of technology, and the lack of incentives for efficient performance were some of the other issues that came under criticism.

Moving from where the system is now, to where it might be ideally, the workshops generated a great number of ideas:

-- First, decentralization was proposed to make the health care system more responsive to local needs. It was discussed from several angles -- ranging from complete fiscal and executive decentralization to decentralization of planning only.

-- A second theme was data and information. Participants discussed support levels for basic, applied and clinical research; considered systems to monitor health programs and policies; and stressed the importance of a province-wide data base.

-- Funding and incentives received attention as means of promoting innovation and efficiency in the system.

-- Co-ordination was a high priority, with the ministry urged to take the leadership position in co-ordinating all health and health-related activities.

-- Professional training was discussed from the perspective of fostering a multi-disciplinary approach to health care.

-- The groups suggested that public education should be improved to encourage individual responsibility for health as well as appropriate utilization of services.

-- Alternative delivery systems and re-defined professional roles received support as means of encouraging multi-disciplinary teams as well as better use of trained personnel.

-- Finally, public and provider involvement in planning was a trend the workshops felt should be advanced.

These eight issues then were taken to the regional conferences hosted by district health councils. They were presented as a framework for discussion, to measure how accurately they reflected perceptions of the health care system at the local level throughout the province.

As you know, a conference was held in each of the ministry's six planning regions over the short space of eight weeks, from the end of May to the end of July. About 100 delegates were invited to each event.

The regional conferences emphasized that health is related to social, economic and environmental conditions and delegates overwhelmingly recommended a stronger focus on health promotion. This new thrust would shift the orientation of our present system from treatment to prevention, and require people to take more responsibility for their own health.

The ministry was urged to reinforce its public education programs through initiatives aimed specifically at:

-- primary school children;

-- high risk groups, such as the elderly;

-- receptive audiences, such as pregnant women and people recovering from heart attacks; and

-- health care providers, to encourage them to educate their patients in healthy lifestyles.

Some participants, by the way, questioned the potential for changing behaviour through education and suggested instead legislation or incentives as more effective ways of promoting healthful living.

A second priority at the regional conferences was better co-ordination of health-related responsibilities, programs, services and manpower. This was seen as crucial to prevent service duplication, eliminate gaps, integrate health and social services and generally optimize the use of finite resources. The delegates saw effective co-ordination as a way of ensuring effective continuity of care.

Participants also advocated better co-ordination of services at the local level -- particularly in the assessment, placement and care of the elderly, psychiatric patients and other groups likely to require the services of more than one agency. The preparation of a directory of health-related services was proposed to help both providers and consumers obtain access to the available programs.

While they favoured a strong central policy and a provincial strategic plan, they also recommended that a local body, such as the district health council, take responsibility for co-ordinating local planning efforts, with care for the elderly to be a top planning priority.

Next, the regional conferences identified community-based programs and alternative delivery systems as a major issue. These community health measures were seen as steps toward several key objectives. They represent less costly alternatives to institutional care and they promise a more personal style of care, closer to people in their homes and in a familiar environment.

Delegates noted, however, that if community-based programs are to offer a real alternative to traditional hospital care, consumers will have to be educated about their quality, value and availability. The ministry was also urged to support and expand community-based programs which have proven effective, and to employ incentives to encourage home care and mutual support groups.

A fourth major issue which came into focus at the conference workshops was accessibility to health care. The northern Ontario conferences in particular stressed that distance, lack of transportation and a shortage of manpower and facilities in some regions could impede access.

Across the province such factors as language, culture and education were identified as barriers. And financial considerations such as user fees, extra billing, OHIP premiums and travel expenses were viewed as potential problem areas.

On the other hand, some participants were concerned that access to health care was too easy. They argued that the system was being misused because services were so readily available at little perceived cost to either consumer or provider.

The ministry was urged to strengthen its efforts to attract qualified personnel -- with appropriate language skills -- to work in underserviced areas. Delegates also proposed that the roles of various health professions be reviewed in order to shift some of the workload of physicians to other practitioners in remote locations.

The participants recognized that all these proposals for change would have to be financed by the reallocation of funds within the system. They suggested that all existing programs should be evaluated for cost-effectiveness, and that reallocation decisions be based on those results.

It was generally agreed that we have failed to exploit the potential of incentives for influencing health care. It was suggested that measures such as tax breaks, lower insurance rates, revisions to the OMA fee schedule, subsidized transportation and matched funding should be used to encourage health promotion and alternative forms of care.

More respite facilities in nursing homes, meals on wheels, day hospital programs and tax incentives, for example, were similarly proposed as concrete measures that would allow more families to keep elderly or disabled relatives at home and out of institutions.

Delegates also discussed deterrent fees as a means of controlling abuse of the system, but could not reach agreement on their effectiveness.

Conference delegates stressed the need for research, evaluation and data. They urged that all new initiatives be tested through pilot projects -- and that the results be made available to support local planning efforts.

They asserted they were not seeking the immediate enactment of expensive new programs. Instead, they advocated a cautious approach to testing and evaluation, and implementation of only those programs which were demonstrated to be cost-effective.

The final item, decentralization, was an unusual issue at the regional conferences. Raised at the Minister's Policy Conference and presented to the regional delegates through background papers, it seemed to be issue that might not have arisen had it not been introduced.

Delegates expressed support for decentralized planning and indicated some interest in decentralized management and evaluation of health programs. In general, participants endorsed the district health council concept and favoured the expansion of DHC responsibilities.

But on the question of decentralizing fiscal and executive authority, opinion varied widely. Of the 37 regional working groups, 21 did not regard this as a major issue and turned their attention to other matters. The remaining participants were split on the idea. Some felt fiscal decentralization would make the system more responsive to local needs, while others feared it would create another costly level of bureaucracy and expose budget decisions to local political pressures.

It becomes obvious, I think, that the topics highlighted at these two steps of the consultation process begin to show a distinct shift in focus.

The number one issue at the Minister's Policy Conference was decentralization. At the regional level, however, decentralization rated much lower and, as I mentioned, may have been a forced issue.

What emerged as the priority issue at the regional conferences was health promotion. In April, health promotion was way down the list.

In general terms, I believe it is fair to say that the regional delegates were far more interested in the more immediate care-related matters, such as barriers to access or the need for chronic care beds, than in discussing the broader systems issues such as decentralization or the value of proper research.

While the conferences pointed to these varying emphases as well as some different rankings in priorities, they also point to what are now our common concerns. We must be prepared to take them seriously and to seek out their implications for our province's health care system.

The challenge now is to keep the momentum for the evolutionary reform of the system alive -- and to sustain broad participation by both providers and consumers of health care in designing the future shape of the system.

The priority setting stage is now complete and represents the work of nearly 1,000 people active in health care in this province. Next month the ministry will publish a detailed report setting forth the conclusions of all the conferences. Copies will be made available to all participants and their organizations. Once they have had the opportunity to study the detailed findings, I am asking the various groups to then provide me with their written comments and suggestions on how we now move the next phase in developing these themes.

A number of options come quickly to mind, such as assigning responsibility for the process to one of the advisory bodies to the ministry, or appointing a task force or series of task forces on specific issues. I am sure the members of the health care community could suggest other approaches and I am ready to receive your comments on this question.

I wish to assure all the groups who have worked so hard to make this consultation process a success that your participation and contribution will continue to be sought -- as we now work to refine in more specific detail the recommendations which the first phase of this process has developed.

From the reports prepared by the conference workshops, and from the comments received on the conference evaluation forms, it is clear that you wish to continue to share in planning for the future of our health care system.

I welcome your enthusiasm. I also want to emphasize that your participation in the process implies a willingness to share the responsibility for implementing the proposals which are ultimately accepted. I hope you will be prepared, in other words, to share with the ministry and me the task of leadership, as we now work to strengthen our health care system to meet the challenges of this decade and beyond.

# Appendix C

## Methodology

### Synthesis of Minister's Policy Conference data

All points made by group members dealing with workshop topics and recorded in recorders' notes were collected for this report. An independent reader went through the notes a second times to ensure all relevant points were recorded.

Any points listed by participants on evaluation forms as possible "lost" issues were recorded and inserted in appropriate sections of the report.

Attempts were made, where possible, to retain original wording of comments. However, when more than one group made the same point, some wordings were altered or combined.

### Synthesis of regional conference data

Five data sources from the regional conferences were used to prepare a common data base for the report:

- Regional reports
- Reporter's notes
- Recorder's notes
- Debriefing session index cards
- Work group flip charts

"Data" included comments, notes, etc., that conveyed discrete ideas. By putting common or related ideas together, 16 categories were determined to fit most data. Some infrequent ideas were put into an "other" category.

In addition, data were cross-referenced using these 17 categories so dimensions of any health issue or topic could be identified. For example, the issue of accessibility included geographic, functional, financial, and utilization dimensions. The issue of funding, on the other hand, included a dimension of accessibility.

Staff from the Ministry of Health and Ontario Council of Health synthesized data to determine themes for the report. Every effort was made to retain integrity of ideas and to include all ideas whether consensus was reached regardless of the number of groups discussing the issue or reaching consensus on it.

# Appendix D

## Minister of Health's Policy Conference

**Date:** April 24-27, 1983

**Location:** The Renaissance Hotel, Scarborough

**Convened by:** Ontario Council of Health

**Organizations represented:**

Association of Independent Physicians of Ontario
Association of Ontario Boards of Health
Association of Ontario Health Centres
Baycrest Centre Foundation
Canadian Mental Health Association, Ontario Division
Canadian Union of Public Employees
Catholic Health Conference of Ontario
College of Family Physicians of Canada, Ontario Chapter
College of Nurses of Ontario
College of Optometrists
College of Physicians and Surgeons of Ontario
Concerned Friends of Ontario Citizens in Care Facilities
Consumers' Association of Canada (Ontario)
Council of Ontario Universities
District Health Councils
Medical Reform Group
Nellie's Hostel for Women
Ontario Advisory Council for Senior Citizens
Ontario Association for Mentally Retarded
Ontario Association of Homes for the Aged
Ontario Association of Optometrists
Ontario Chiropractic Association
Ontario College of Pharmacists
Ontario Council of Health
Ontario Council of University Health Sciences
Ontario Dental Association
Ontario Health Coalition
Ontario Hospital Association
Ontario Medical Association
Ontario Mental Health Foundation
Ontario Ministry of Health
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario Psychiatric Association
Ontario Public Health Association
Patients' Rights Association

Professional Association of Interns and
Residents of Ontario
Registered Nurses' Association of Ontario
Royal College of Dental Surgeons
United Senior Citizens of Ontario
Women's Counselling Referral & Education Centre

**Program:**

April 24, 1983

| | |
|---|---|
| 4:00-6:45 p.m. | Registration |
| 7:00 p.m. | Welcome<br>Brian Holmes, Chairman,<br>Ontario Council of Health |
| | Dinner |
| | Keynote Address<br>The Honourable Larry Grossman,<br>Minister of Health |
| | Description of the Conference<br>Rick Carlson, Conference Facilitator |
| | Cash Bar |

April 25, 1983

| | |
|---|---|
| 7:00-8:15 a.m. | Buffet Breakfast |
| 8:30 a.m. | "The Current System - Its Successes and Shortcomings"<br>Robert Evans, Professor, Department of Economics, University of British Columbia |
| 9:00 a.m. | Workshop #1: The Current System - Its Successes and Shortcomings |
| 11:00 a.m. | Break |
| 11:45 a.m. | Reporting Back and Synthesis of Workshop #1<br>Rick Carlson |
| | Lunch |
| | "Trends and Opportunities for Change"<br>Brian Abel-Smith, Professor, Department of Social Science and Administration, London School of Economics and Political Science |
| 1:30 p.m. | Workshop #2: Trends and Opportunities for Change |
| 3:30 p.m. | Snack Break |

| | |
|---|---|
| 4:00 p.m. | Reporting Back and Synthesis of Workshop #2<br>Rick Carlson |
| 4:30 p.m. | Workshop #3: Desired Directions for Health and Health Care |
| 6:30 p.m. | Cash Bar |
| 7:00 p.m. | Dinner |
| | "Desired Directions for Health and Health Care"<br>Arnold Naimark, President, University of Manitoba |
| 8:30 p.m. | Social Activities |

April 26, 1983

| | |
|---|---|
| 7:00-8:15 a.m. | Buffet Breakfast |
| 8:30 a.m. | "Preparation of Action Steps/Strategic Planning"<br>Edward Roberts, Professor, Alfred Sloan School of Management, Massachusetts Institute of Technology |
| | Reporting Back and Synthesis of Workshop #3<br>Rick Carlson |
| 9:30 a.m. | Workshop #4: Preparation of Action Steps |
| 12:00 noon | Lunch |
| 1:30 p.m. | Workshop #4 continues |
| 3:30 p.m. | Break |
| 4:00 p.m. | Workshop #4 continues<br>Large Group Workshops: Recommendations for Action |
| 5:30 p.m. | Cash Bar |
| 6:00 p.m. | Dinner |
| | Panel Discussion<br>Robert Evans, Brian Abel-Smith, Arnold Naimark, Edward Roberts |
| 8:30 p.m. | Social Activities |

April 27, 1983

| | |
|---|---|
| 7:30-8:45 a.m. | Buffet Breakfast |
| 9:00-12:00 noon | Plenary Session<br>Chairman<br>The Honourable Larry Grossman,<br>Minister of Health |
| | Presentation of Conference Strategic Plan<br>Rick Carlson |
| | Reporting Back and Synthesis of Workshop #4 |
| | Closing Remarks |

**Priorities emerging the Minister's Policy Conference:**

Decentralization

Data and Information - need for provin[illegible] wide data base

Funding and Incentives

Co-ordination of health and health-related activities

Professional training - multi-disciplinary approach

Public Education - to encourage individual responsibility for health and appropriate use of services

Alternative delivery services and re-definition of professional roles

Public and provider involvement in planning

# Appendix E

## Northwestern Regional Conference

**Date:** May 27-28, 1983

**Location:** Confederation College, Thunder Bay

**Convened by:** Kenora-Rainy River District Health Council
Thunder Bay District Health Council

**Area covered:** District of Kenora
District of Rainy River
District of Thunder Bay

**Organizations represented:**

Addiction Research Foundation
Advisory Council on the Physically Handicapped
Anishnabequek Association
Association des Francophones
Association of Ontario Boards of Health
Canadian Mental Health Association, Ontario Division
Canadian Red Cross Society, Ontario Division
Catholic Health Conference of Ontario
Concerned Friends of Ontario Citizens in Care Facilities
Confederation College
Emergency Measures Organization
Handicapped Action Group Inc.
Health Centre, Ear Falls
Kenora-Rainy River District Health Council
Lakehead Association for the Mentally Retarded
Lakehead Labour Council
Lakehead University, Thunder Bay
North of Superior Mental Health Program
Northern Ontario Medical Program
Northern Outreach Program
Northwestern Ontario Crippled Children Centre
Northwestern Ontario Women's Centre
Ontario Association of Health Centres
Ontario Association of Optometrists
Ontario Association of Professional Social Workers
Ontario Cancer Treatment and Research Foundation
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Health
Ontario Dental Association
Ontario Dietetic Association
Ontario Hospital Association
Ontario Medical Association
Ontario Ministry of Community and Social Services

Ontario Ministry of Health
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Psychological Association
Ontario Public Health Association
Ontario Society of Medical Technologists
Ontario Society of Occupational Therapists
Palliative Care, St. Joseph's General Hospital, Thunder Bay
Placement Co-ordination Services, Thunder Bay
Registered Nurses' Association of Ontario
Senior Citizens' Inter-Group Council, Thunder Bay
Society of Medical Officers of Health
St. John Ambulance, Ontario Council
Thunder Bay District Health Council
Victorian Order of Nurses
Volunteer Action Centre, Thunder Bay

**Priorities emerging from Northwestern Regional Conference:**

Health Promotion

Accessibility

Co-ordination

Community-Based Programs

Decentralization

# Appendix F

## Eastern Regional Conference

**Date:** June 3-4, 1983

**Location:** Delta Hotel, Ottawa

**Convened by:**
Kingston, Frontenac and Lennox and Addington District Health Council
Lanark, Leeds & Grenville District Health Council
Ottawa-Carleton Regional District Health Council
Seaway Valley District Health Council

**Area covered:**
Regional Municipality of Ottawa-Carleton
County of Frontenac
County of Hastings
County of Lanark
United Counties of Leeds and Grenville
County of Lennox and Addington
United Counties of Prescott and Russell
County of Prince Edward
County of Renfrew
United Counties of Stormont, Dundas and Glengarry

**Organizations represented:**
Algonquin College
Area Women's Institute
Association of Boards of Health
Association of Independent Physicians
Association of Municipalities of Ontario
Association of Ontario Health Centres
Canadian Mental Health Association, Ontario Division
Catholic Health Conference of Ontario
Council for the Disabled, Ottawa
Council on Aging, Ottawa
Drug and Alcohol Teen Awareness
Group for Medical Reform
Kingston Regional Association for Health Education and Social Services
Health Sciences Centre, Ottawa
Interagency Council for Children
Kingston Area Regional Council on Drugs and Alcohol
Kingston Regional Ontario Speech and Hearing Association
Kingston, Frontenac and Lennox and Addington District Health Council

Lanark, Leeds and Grenville District Health Council
Leeds and Grenville Children's Services Steering Committee
Ontario Association of Professional Social Workers
Ontario Association of Homes for the Aged
Ontario Association of Medical Technologists
Ontario Association of Optometrists
Ontario Association of Visiting Homemaker Services
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Health
Ontario Dental Association
Ontario Dietetic Association
Ontario Health Coalition
Ontario Hospital Association
Ontario Medical Association
Ontario Ministry of Community and Social Services
Ontario Ministry of Health
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario Psychiatric Association
Ontario Psychological Association
Ontario Public Health Association
Ontario Rest Homes Association
Ontario Society of Medical Technologists
Ontario Society of Occupational Therapists
Ottawa-Carleton Regional District Health Council
Placement Co-ordination Service, Ottawa
Registered Nurses' Association of Ontario
Seaway Valley District Health Council
Social Planning Council, Kingston
Social Planning Council, Ottawa
Society of Medical Officers of Health
St. Lawrence College of Applied Arts and Technology, Brockville
Victorian Order of Nurses
Voluntary Children's Services Co-ordinating Committee

**Priorities emerging from Eastern Regional Conference:**

Co-ordination

Accessibility

Health Promotion

Community-Based Services

Funding

# Appendix G

## Southwest Regional Conference

**Date:** June 17-18, 1983

**Location:** Holiday Inn, City Centre, London

**Convened by:**
Essex County District Health Council
Grey-Bruce District Health Council
Kent County District Health Council
Lambton District Health Council
Thames Valley District Health Council

**Area covered:**
County of Bruce
County of Elgin
County of Essex
County of Grey
County of Huron
County of Kent
County of Lambton
County of Middlesex
County of Oxford
County of Perth

**Organizations represented:**
Addiction Research Foundation
Association Canadienne-Française de l'Ontario
Association of Ontario Health Centres
Bruce Grey Children's Services
Canadian Cancer Society
Canadian Mental Health Association, Ontario Division
Canadian Red Cross Society, Ontario Division
Catholic Health Conference of Ontario
Coalition for Seniors
Concerned Farm Women
Concerned Friends of Ontario Citizens in Care Facilities
Council for Action for Alcoholism and Drugs
Emergency Nurses Association
Essex County District Health Council
Greenshields Prescription Plan
Grey-Bruce District Health Council
Kent County Children's Treatment Centre
Kent County District Health Council
Lambton District Health Council
Lester B. Pearson Centre for Children and Youth
London Area Mental Retardation Working Group
London Council of Women

Medical Reform Group of Ontario
Multi-Service Centre, Tillsonburg
Ontario Association of Homes for the Aged
Ontario Association of Professional Social Workers
Ontario Association of Optometrists
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Health
Ontario Dental Association
Ontario Hospital Association
Ontario Medical Association
Ontario Ministry of Health
Ontario Native Women's Association
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Public Health Association
Ontario Society of Medical Technologists
Ontario Society of Occupational Therapists
Registered Nurses' Association of Ontario
Society of Medical Officers of Health
St. John's Ambulance, Ontario Council
Thames Valley District Health Council
University of Western Ontario
University of Windsor
Victorian Order of Nurses

**Priorities emerging from Southwest Regional Conference:**

Co-ordination

Funding and Incentives

Health Promotion

Data/Research/Evaluation

Community-Based Services

# Appendix H

## Central West Regional Conference

**Date:** June 24-25, 1983

**Location:** Waterloo Motor Inn, Waterloo

**Convened by:**
Brant District Health Council
Haldimand-Norfolk District Health Council
Halton District Health Council
Hamilton-Wentworth District Health Council
Niagara District Health Council
Waterloo Region District Health Council
Wellington-Dufferin District Health Council

**Area covered:**
Regional Municipality of Haldimand-Norfolk
Regional Municipality of Halton
Regional Municipality of Hamilton-Wentworth
Regional Municipality of Niagara
Regional Municipality of Waterloo
County of Brant
County of Dufferin
County of Simcoe
County of Wellington

**Organizations represented:**
Addiction Research Foundation
Association of General Hospital Psychiatric Services/Halton
Association Canadienne-Française de l'Ontario
Association of Ontario Health Centres
Brant District Health Council
Brantford Ethnic Festival and Cultural Society
Canadian Mental Health Association, Ontario Division
Catholic Health Conference of Ontario
Community Mental Health Clinic, Guelph
Community Mental Health Coalition, Niagara
Concerned Friends of Ontario Citizens in Care Facilities
Gerontology Research Council of Ontario
Gotthard-Booth Society, Kitchener
Haldimand-Norfolk District Health Council
Haldimand-Norfolk Roman Catholic School Board
Halton District Health Council
Hamilton-Wentworth District Health Council
Health and Allied Disciplines Committee, Regional Municipality of Waterloo
Health and Social Services Committee, Regional Municipality of Waterloo

Joint Social Services Committee, Wellington County Administration Centre
Kitchener-Waterloo Rotary Children's Centre
Lansdowne Children's Centre
McMaster University, Hamilton
Medical Reform Group of Ontario
Niagara College
Niagara District Health Council
Ontario Association of Homes for the Aged
Ontario Association of Optometrists
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Administrators of Teaching Hospitals
Ontario Council of Health
Ontario Dental Association
Ontario Health Coalition
Ontario Hospital Association
Ontario Medical Association
Ontario Ministry of Health
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Public Health Association
Regional Municipality of Halton
Registered Nurses' Association of Ontario
Senior Citizens Department, Regional Municipality of Niagara
Six Nations Indian Reserve
Social Planning and Research Council of Hamilton and District
Society of Medical Officers of Health
University of Guelph
Victorian Order of Nurses
Waterloo Region District Health Council
Waterloo Region Social Resources Council
Wellington-Dufferin District Health Council

**Priorities emerging from Central West Regional Conference:**

Incentives

Co-ordination and Planning

Health Promotion

Data/Research/Evaluation

Community-Based Services

Decentralization

# Appendix I

## Central East Regional Conference

**Date:** July 8-9, 1983

**Location:** Prince Hotel, Toronto

**Convened by:**
Durham Region District Health Council
Haliburton, Kawartha and Pine Ridge District Health Council
Metropolitan Toronto District Health Council
Peel District Health Council

**Area covered:**
Municipality of Metropolitan Toronto
Regional Municipality of Durham
Regional Municipality of Peel
Regional Municipality of York
District Municipality of Muskoka
County of Haliburton
County of Northumberland
County of Peterborough
County of Victoria

**Organizations represented:**
Addiction Research Foundation
Association of Ontario Boards of Health
Association of Ontario Health Centres
Board of Directors of Masseurs
Canadian Cancer Society
Canadian Diabetes Association, Ontario Division
Canadian Mental Health Association, Ontario Division
Canadian National Institute for the Blind
Canadian Pensioners Concerned
Canadian Red Cross Association, Ontario Division
Catholic Health Conference of Ontario
Children's Aid Society of Peel
City of Oshawa
Community Resources Consultants of Toronto
Concerned Friends of Ontario Citizens in Care Facilities
Consumers' Association of Canada (Ontario)
County of Northumberland
Durham Region Community Care Associates
Durham Region District Health Council
Durham Region Social Services Committee
Five Counties Children's Centre, Lindsay
Haliburton County Home Support Services
Haliburton, Kawartha and Pine Ridge District Health Council

Health Sciences Centre, University of Toronto
Home Care Program for Metropolitan Toronto
Hospital Council of Metropolitan Toronto
Kawartha Participation Project
Kidney Foundation of Canada
Medical Reform Group of Ontario
Metropolitan Toronto Ambulance Service
Metropolitan Toronto District Health Council
Metropolitan Toronto Health Professionals Council
Multiple Sclerosis Society of Canada, Ontario Division
Northern Health Area Community Advisory Board, Toronto
Ontario Association of Homes for the Aged
Ontario Association of Optometrists
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Health
Ontario Dental Association
Ontario Dietetic Association
Ontario Health Coalition
Ontario Heart Foundation
Ontario Hospital Association
Ontario Lung Association
Ontario Medical Association
Ontario Ministry of Health
Ontario Ministry of Industry and Trade
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Psychological Association
Ontario Public Health Association
Oshawa Clinic
Patients' Rights Association
Peel Board of Education
Peel District Health Council
Rape Crisis Centre, Toronto
Registered Nurses' Association of Ontario
Rest Homes Association of Ontario
Simcoe County District Health Council Steering Committee
Social Planning Council of Metropolitan Toronto
Social Planning Council of Peel
Society of Medical Officers of Health
St. John's Ambulance, Ontario Council
Victorian Order of Nurses
Volunteer Centre of Peel
Whitby Ambulance Service
Whitby Psychiatric Hospital Advisory Board

**Priorities emerging from Central East Regional Conference:**

Health Promotion (Environment issues)

Co-ordination and Planning

Funding and Incentives

Data/Research/Evaluation

Alternative Delivery Systems

Decentralization

# Appendix J

## Northeastern Regional Conference

**Date:** July 22-23, 1983

**Location:** Holiday Inn, Sudbury

**Convened by:**
Algoma District Health Council
Cochrane District Health Council
Manitoulin-Sudbury District Health Council

**Area covered:**
Regional Municipality of Sudbury
District of Algoma
District of Cochrane
District of Manitoulin
District of Nipissing
District of Parry Sound
District of Sudbury
District of Timiskaming

**Organizations represented:**
Algoma District Health Council
Association Canadienne-Française de l'Ontario
Association of Boards of Health
Association of Ontario Health Centres
Canadian Mental Health Association, Ontario Division
Canadore College
Catholic Health Conference of Ontario
Cochrane District Health Council
College of Nurses of Ontario
COM-SAC
Franco-Femmes
James Bay General Hospital
Laurentian University
Manitoulin-Sudbury District Health Council
Northeastern Ontario Senior Citizens Association
Northern Outreach Program
Ontario Association for the Mentally Retarded
Ontario Association of Homes for the Aged
Ontario Association of Optometrists
Ontario Association of Professional Social Workers
Ontario Chapter, College of Family Physicians of Canada
Ontario Chiropractic Association
Ontario Council of Health
Ontario Dental Association
Ontario Health Coalition
Ontario Hospital Association

Ontario Medical Association
Ontario Ministry of Health
Ontario Nursing Home Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Public Health Association
Ontario Separate School Trustee Association
Ontario Speech and Hearing Association
Ontario Society of Occupational Therapists
Regional Children's Services, Sudbury-Algoma Hospital
Registered Nurses' Association of Ontario
Sault Ste. Marie and District Labour Council
Society of Medical Officers of Health
South Cochrane Child and Youth Services
Sudbury Women's Centre
The Denturist Association of Ontario
United Way/Sudbury and District
Union of Ontario Indians
Victorian Order of Nurses
Women in Crisis Centre, Sault Ste. Marie

**Priorities emerging from Northeastern Regional Conference:**

Co-ordination and Planning

Accessibility

Special Needs (Community-Based Services)

Funding

Education (as a means of promoting health)

Decentralization

# Appendix K

## Sample regional conference program

### Day One

| | |
|---|---|
| 1:00-2:00 p.m. | Registration |
| 2:00 p.m. | Welcome<br>Conference Chairman |
| | Keynote Address<br>Minister of Health |
| | "Strategic Planning"<br>Andre Spekkens, Executive Director,<br>Essex County District Health Council |
| | "Strengths and Weaknesses in Ontario's Health Care System Today" |
| | Thoughts from the Minister's Policy Conference<br>Brian Holmes, Chairman,<br>Ontario Council of Health, or<br>George Ingram, Immediate Past President,<br>Ontario Hospital Association |
| | Introduction to Workshop Sessions<br>Conference Facilitator<br>Jay Browne, Director, Department of Social Work,<br>Chedoke-McMaster Hospital, or<br>Milton Orris, Dean of Continuing Education,<br>Ryerson Polytechnical Institute |
| 4:15 p.m. | Workshop Sessions |
| 6:00 p.m. | Cash Bar |
| 6:30 p.m. | Dinner |
| 7:30 p.m. | Workshop Sessions continue |
| 9:00 p.m. | Cash Bar |

**Day Two**

| | |
|---|---|
| 8:00 a.m. | Breakfast |
| | Remarks by<br>Graham Scott, Deputy Minister of Health,<br>Allan Dyer, Associate Deputy Minister of Health,<br>Darwin Kealey, Assistant Deputy Minister of Health, or<br>Boyd Suttie, Assistant Deputy Minister of Health |
| | Summary of "Strengths and Weaknesses"<br>Workshops<br>Conference Facilitator<br>Jay Browne, Director, Department of Social Work,<br>Chedoke-McMaster University, or<br>Milton Orris, Dean of Continuing Education,<br>Ryerson Polytechnical Institute |
| | "Proposals for Change: Health Care<br>the 80s and Beyond" |
| | Ideas from the Minister's Policy Conference<br>Brian Holmes, Chairman,<br>Ontario Councl of Health, or<br>George Ingram, Immediate Past President,<br>Ontario Hospital Association |
| 9:30 a.m. | Workshop Sessions |
| 12:00 noon | Lunch |
| 1:00 p.m. | Workshop Sessions continue |
| 2:30 p.m. | Presentation of Workshop Reports |
| 3:30 p.m. | Conference Closing |